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(1)

No. 08-

IN THE

Supreme Court of the United States

CHARLIE D. BROWN, Trustee of the Katelyn Andrews Segregated Settlement Account,

Petitioner,

v.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE NORTH CAROLINA SUPREME COURT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the North Carolina Supreme Court's application of N.C. Gen.Stat. § 180A-57(a) fails to comply with federal anti-lien laws and with this Court's ruling in *Ahlborn v. Arkansas Dept. of Human Services*, 126 S. Ct. 35, 545 U.S. 1165, 162 L.Ed.2d 933 (2005) by establishing an irrebuttable presumption allowing Medicaid to obtain reimbursement of 100% of its actual past medical expenses up to a cap of one-third of the proceeds of a Medicaid beneficiary's personal injury settlement or recovery, without permitting any judicial determination of the amount actually allocable to medical expenses?

LIST OF ALL PARTIES TO THE PROCEEDING

The parties to this proceeding[1] are:

Charlie D. Brown, Trustee of the Katelyn Andrews Segregated Settlement Account, Petitioner; and,

The North Carolina Department of Health and Human Services, Division of Medical Assistance ("DMA"), Intervenor-Respondent.

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[1] The parties to the original state court proceedings were: Katelyn Andrews, a minor, through her Guardian ad litem, David Andrews; David Andrews and Andrea Andrews, individually; Vanessa P. Haygood, M.D., an individual; Central Carolina Obstetrics and Gynecology, P.A., a North Carolina Corporation; The Women's Hospital Of Greensboro, a North Carolina Not for Profit Corporation and Kim Richey, RN, individually, and Jennifer Daley, individually. These parties did not make any submissions to the North Carolina Court of Appeals or to the North Carolina Supreme Court.

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CITATION OF REPORTS OF OPINIONS ENTERED IN THIS CASE

Andrews, ex rel. Andrews v. Haygood, __ NC App __, 655 S.E.2d 440 (N.C. App. January 15, 2008).

Andrews, ex rel. Andrews v. Haygood, 362 N.C. 599, 669 S.E.2d 310 (December 12, 2008).

Petitioner respectfully petitions for a Writ of Certiorari to review the judgment of the North Carolina Supreme Court in this case.

STATEMENT FOR BASIS OF JURISDICTION

The North Carolina Supreme Court entered its judgment on December 12, 2008. Petitioner Charlie Brown, Trustee, seeks review of that judgment on a writ of certiorari. The present petition is timely filed pursuant to 28 U.S.C. § 2101(c) and Rule 13.3 of this Court. Petitioner invokes this Court's jurisdiction to review the decision of the North Carolina Supreme Court under 28 U.S.C. § 1257a.

STATUTORY PROVISIONS INVOLVED IN THIS CASE

The following statutes and regulations are set forth in the Appendix pursuant to Supreme Court Rule 14(1)(f):

United States Code excerpts:
42 U.S.C. § 1396a (App. 95-103)
42 U.S.C. § 1396k (App. 104-106)
42 U.S.C. § 1396p (App. 106-139)

North Carolina General Statutes:
N.C. Gen.Stat. §108A-56 (App. 144)
N.C. Gen.Stat. §108A-57 (App. 145-146)
N.C. Gen.Stat. §108A-59 (App. 147)

U.S.C.A. Const. Art. VI, cl.2 (App. 94).

In addition, the following provision of the United States Constitution is at issue in this case:

U.S.C.A. Const. Art. I § 10, cl. 1, which states:

> No State shall enter into any Treaty, Alliance, or Confederation; grant Letters of Marque and Reprisal; coin Money; emit Bills of Credit; make any Thing but gold and silver Coin a Tender in Payment of Debts; pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility.
>
> No State shall, without the Consent of the Congress, lay any Imposts or Duties on Imports or Exports, except what may be absolutely necessary for executing its inspection Laws: and the net Produce of all Duties and Imposts, laid by any State on Imports or Exports, shall be for the Use of the Treasury of the United States; and all such Laws shall be subject to the Revision and Control of the Congress.
>
> No State shall, without the Consent of Congress, lay any duty of Tonnage, keep

> Troops, or Ships of War in time of Peace, enter into any Agreement or Compact with another State, or with a foreign Power, or engage in War, unless actually invaded, or in such imminent Danger as will not admit of delay.

STATEMENT OF THE CASE

This case arises out of a claim by the North Carolina Division of Medical Assistance (hereinafter "DMA" or "Medicaid") against settlement funds paid to minor Katelyn Andrews and her parents in connection with a medical malpractice claim for catastrophic injuries incurred during Katelyn's birth. (App. 2-3) Katelyn and her parents settled all claims against the doctors and hospital out of court pursuant to two confidential Settlement Agreements.[2] (App. 26-27) No allocation was made in the Settlement Agreements as to the amount of damages attributable to medical expenses as opposed to other types of damages. (App. 20) The Court established the Katelyn Andrews Segregated Settlement Account ("Settlement Account") for receipt of the settlement funds for Katelyn's benefit, and the Petitioner Charlie D. Brown was appointed as Trustee to administer the settlement funds deposited into the account. (App. 27)

DMA thereafter intervened in the proceedings and sought payment in full from the settlement funds of the past medical expenses paid by Medicaid in connection

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[2] Due to the confidential provisions in the agreements, the original settlement documents were filed under seal pursuant to Court order.

with Katelyn's injuries. (App. 27) By motion filed, the Trustee asked the trial court for an evidentiary hearing pursuant to this Court's ruling in *Ahlborn v. Arkansas Dept. of Human Services* to determine the allocation of the settlement between past medical expenses versus other types of damages such as future medical expenses, lost earning capacity, pain and suffering, and loss of consortium. (App. 40-41)

The trial court denied the Trustee's request for an evidentiary hearing to determine the pro rata portion of the settlement allocable to the Petitioner's past medical expenses relative to the value of the claim as a whole. (Appendix C, App. 40-41)[3] The trial court found that DMA was subrogated to the minor child's right of recovery "[p]ursuant to N.C. Gen.Stat. §108A-59 and § 108A-57(a) and *Ezell v. Grace Hospital*," and ordered payment in full without making any allocation of the settlement proceeds. (App. 40-41)

The denial of the Trustee's request was based on the North Carolina Supreme Court decision of *Ezell v. Grace Hospital*, 360 N.C. 529, 631 S.E.2d 131 (2006). (App. 41) *Ezell* held that no hearing or allocation was necessary because North Carolina's Medicaid lien statute was *not* limited to recovery against amounts attributable to past medical expenses. (App. 93; App.

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[3] Although the original order was filed under seal, the excerpts of the findings of fact and conclusions of law submitted by the Petitioner in the Appendix contain information which is now public record pursuant to the North Carolina Court of Appeals and Supreme Court decisions below, including the amount of expenses awarded to DMA. (App. 40-41)

88-92). Notwithstanding the Supremacy Clause of the United States Constitution (App. 94), the trial court stated in Conclusion of Law #7:

> The trustee's request for the court to consider and take evidence relating to the reasonable value of the case in relation to the amount of past medical expenses, or to otherwise allocate the settlement amounts under *Arkansas v. Ahlborn* . . . should be denied because the North Carolina Supreme Court's decision in *Ezell v. Grace Hospital* . . . is controlling.

(App. 41)

The Trustee timely appealed the trial court's ruling to the North Carolina Court of Appeals. The North Carolina Court of Appeals issued its Opinion on January 15, 2008 upholding the trial court's ruling, with one justice dissenting. (Appendix B) The majority opinion issued by the Court of Appeals in *Andrews* held that the trial court did not err in subrogating the settlement to DMA in the full amount paid by DMA for past medical expenses, finding that the settlement was subject only to the statutory one-third cap. (App. 28-31) The Court of Appeals did not reach the issue of whether the trial court should have conducted an evidentiary hearing to determine the pro rata portion of the settlement allocable to Katelyn's past medical expenses. (App. 28, 31, footnotes 1 and 3)

Petitioner Brown timely appealed of right to the North Carolina Supreme Court from the order of the

Court of Appeals issued February 4, 2008 with regard to the issue raised by Judge Wynn's dissent.[4] In a four to three decision, the North Carolina Supreme Court affirmed the decision of the North Carolina Court of Appeals. (Appendix A) The North Carolina Supreme Court found, however, that:

> *Ahlborn* thus does not mandate a judicial determination of the portion of a settlement from which the State may be reimbursed for prior medical expenditures. Instead, the Supreme Court left to the States the decision on the measures to employ in the operation of their Medicaid programs. . . . Rather than requiring a specific determination of the medical expense portion of a settlement, North Carolina employs an alternative statutory procedure that we believe is permitted by *Ahlborn*. [North Carolina] law defines "the portion of the settlement that represents payment for medical expenses" as the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery . . . The one-third limitation of section 108A-57(a) thus comports with *Ahlborn* by providing a reasonable method

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[4] The Petitioner petitioned for discretionary review on the issue of whether the trial court erred in finding that no further hearing or evidence on the total value of Petitioner's overall damages (as opposed to the amount of the lump sum settlement) was required in order to determine the amount to paid in satisfaction of DMA's claim. The Petition for Discretionary Review was granted on April 10, 2008, *Andrews v. Haygood*, 362 N.C. 354, 661 S.E.2d 238 (2008).

> for determining the State's medical reimbursements, which it is required to seek in accordance with federal Medicaid law.

(App. 7-9) (internal citations omitted). The North Carolina Supreme Court concluded: "as we previously did in *Ezell*[5], we have again reviewed section 108A-57(a) and find it to be a reasonable framework that comports with the requirements of federal Medicaid law as interpreted by *Ahlborn*." (App. 10)

REASONS FOR GRANTING THE PETITION

A. *Certiorari is Appropriate Because the North Carolina Supreme Court's Application of N.C.G.S. §108-57(a) Conflicts with the United States Supreme Court's Decision in Ahlborn and Violates Federal Anti-Lien Laws.*

North Carolina's interpretation and application of N.C. Gen. Stat. §108A-57(a) directly conflicts with this Court's holding in *Ahlborn*. The instant case presents new issues of national importance to proper application of the federal anti-lien statutes in that: (1) unlike the facts presented in *Ahlborn*, there was no agreed-upon allocation in the Andrews settlement agreements of past medical expenses versus other types of damages; (2) the North Carolina's highest court has held that no such allocation need be made, because North Carolina's statutory scheme provides that DMA is conclusively entitled to recover its actual medical expenses up to the

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[5] *Ezell v. Grace Hospital, Inc*, 175 N.C.App. 56, 623 S.E.2d 79 (2005); 360 N.C. 529, 631 S.E.2d 131(2006) (Appendix E)

one-third statutory cap, and incorrectly has held that this constitutes a permissible alternative to the formula set forth in *Ahlborn*. (*See*, App. 6-10)

As noted by the Dissent below, the Majority's interpretation of N.C. Gen. Stat. §108A-57(a) is a "blanket determination" that the medical expense portion of a settlement is always the full amount of actual expenses up to one-third. (*Dissenting Opinion*, App. 21). The Court's interpretation of N.C. Gen. Stat. §108A-57(a) does not permit any other allocation, unless plaintiffs can negotiate a settlement with the State for an amount less than that required by North Carolina statutes. (App. 8) In effect, the North Carolina Supreme Court has held that the one-third cap acts as a substitute for a factual determination on the allocation of damages, without basing such a decision on any legislative history. This application of North Carolina's statute violates the federal anti-lien provisions in 42 U.S.C. §§ 1396p and 1396a because, as in *Ahlborn*, DMA may recover more than those damages properly allocable to reimbursement for past medical expenses.

1. *The Holding in Ahlborn.*

On May 1, 2006 this Court rendered its unanimous opinion in *Ahlborn v. Arkansas Dept. of Human Services*, 126 S. Ct. 35, 545 U.S. 1165, 162 L.Ed.2d. 933 (2005) (Appendix D). The *Ahlborn* decision significantly impacted how and to what extent state Medicaid agencies can seek reimbursement from personal injury settlements.[6]

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[6] As discussed further below, a number of other states (including those which used a statutory cap) have amended their statutory schemes to comply with *Ahlborn*.

Interpreting 42 U.S.C. §1396k(a)(1)(A), which provides that Medicaid recipients must "assign the State any rights . . . to payment for medical care from any third party," (emphasis added), the *Ahlborn* Court held that Medicaid could not lay claim to more than that portion of a Medicaid beneficiary's third party settlement that represented payment for past medical expenses. *Id.*, 126 S. Ct. at 1761, 547 U.S. at 281. (App. 59-63) In *Ahlborn*, the Court also held that 42 U.S.C. §1396p(a)(1), the federal "anti-lien statute," clearly prohibited the placement of a lien on third party liability claims asserted by a Medicaid beneficiary, except to the extent that 42 U.S.C. §1396a(a)(25)(H) and 42 U.S.C. §1396k(a)(1) permitted states to recover from third party payments for medical care. *Ahlborn*, 126 S. Ct. at 1762-1763, 547 U.S. at 282-285. (App. 63-68)

> Federal Medicaid law does not authorize [the state agency] to assert a lien on [a beneficiary's] settlement in an amount exceeding [the pro rata portion designated as reimbursement for medical payments made], and the federal anti-lien provision affirmatively prohibits it from doing so. [The State's] third-party liability provisions are unenforceable insofar as they compel a different conclusion.

Id. at 292, 126 S.Ct at 1767,164 L.Ed.at 479. (App. 75-76) Because the federal Medicaid statute provides that Medicaid recipients must "assign the State any rights . . . to payment for medical care from any third party," Medicaid could not lay claim to more than that portion of a Medicaid beneficiary's third party settlement that

represented payment for past medical expenses. 42 U.S.C. §1396k(a)(1)(A) (App. 104, 106), *Ahlborn*, 126 S. Ct. at 1761, 547 U.S. at 281 (App. 59-60).

2. *North Carolina's Medicaid Lien Statute.*

The North Carolina statutes state that, "by accepting medical assistance, the [Medicaid] recipient shall be deemed to have made an assignment to the State of the right to thirty party benefits," (App. 147), "to the extent of [Medicaid] payments," (App. 145-146), but not exceeding "one-third of the gross amount obtained." *Id.*

Like the Arkansas statutes struck down in *Ahlborn*, *supra*,[7] N.C. Gen.Stat. §§ 108A-57 and 108A-59, read literally, apply broadly to all of a Medicaid beneficiary's rights of recovery against tortfeasors, insurance companies, and other third parties. N.C. Gen.Stat. § 108A--57 provides that the state Medicaid program is "subrogated to all rights of recovery, contractual or otherwise, of the [Medicaid] beneficiary . . . against any person." (Emphasis added.) (App. 145-146) Similarly, N.C. Gen.Stat. § 108A-59 requires the assignment of a Medicaid beneficiary's "right to third party benefits,

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[7] The Arkansas statutes struck down by this Court in *Ahlborn*, namely A.C.A. §§ 20–77–307 and 20–77–302 (Appendix J), are "materially indistinguishable" from North Carolina General Statutes §§ 108A-57 and 108A-59 (App. 145-147). *Andrews*, dissent 655 S.E.2d at 444 (App. 35) According to Arkansas law, a Medicaid beneficiary had to assign "any settlement, judgment, or award which may be obtained against any third party" to the Arkansas Medicaid agency, "to the full extent of any amount which may be paid by Medicaid" for her benefit. A.C.A. §20-77-307(a). (App. 149)

contractual or otherwise," without any express limitation as to the type or scope of these rights or benefits. (App. 147)

Therefore, the North Carolina statutes, §§ 108A-57 and 108A-59, to the extent they allow Medicaid to recover payments from a third party for claims ***other than those for medical expenses,*** suffer from precisely the same defect as Arkansas' Medicaid third party liability statutes which rendered the Arkansas statutes invalid under the federal Medicaid statutes and the *Ahlborn* decision. Where North Carolina law differs from the Arkansas statutes considered in *Ahlborn* is that it imposes a cap on Medicaid's recovery to one-third of the gross amount of the settlement received. N.C. Gen. Stat. §108A-57(a) (App. 145-146) As discussed below, the application of this one-third cap fails to ensure that the Medicaid recovery is properly limited to the portions of settlements relating to medical expenses.

3. *The holding of the North Carolina Supreme Court in Ezell, supra, was that N.C. Gen. Stat. §108A-57(a) did not limit DMA's lien rights to medical expenses.*

The case of *Ezell v. Grace Hospital, Inc.*, 175 N.C.App. 56, 623 S.E.2d 79, 360 N.C. 529, 631 S.E.2d 131(2005) (Appendix E) also involved a medical malpractice claim. In the Court of Appeals, DMA had argued that it was entitled to the full amount that it paid in medical payments on the plaintiff's behalf. The majority of the panel in the Court of Appeals disagreed and held that only a portion of DMA's claim was for medical care resulting from the defendants' alleged

negligence, and therefore limited Medicaid's recovery to that lesser proportionate amount. *Ezell*, 175 N.C. App. at 60-62, 623 S.E.2d at 82-82. (App. 80-83)

DMA appealed from the majority's decision in *Ezell, supra*, and the case was argued in the North Carolina Supreme Court on April 18, 2006 (approximately two weeks before the May 1, 2006 *Ahlborn* decision was published). On June 30, 2006, the North Carolina Supreme Court issued a *per curium* opinion reversing the North Carolina Court of Appeals' majority decision and adopting the dissenting opinion. *Ezell v. Grace Hosp., Inc.*, 360 N.C. 529, 631 S.E.2d 131 (2006), *reversing Ezell v. Grace Hosp., Inc.*, 175 N.C. App. 56, 623 S.E.2d 79 (2005). (App. 93)

That *Ezell* Court of Appeals dissent (which was written prior to and without the guidance of the Supreme Court's decision in *Ahlborn, supra*) stated that N.C.GS. § 108A-57 "entitles the State to *full* reimbursement for *any* Medicaid payments made on a plaintiff's behalf in the event that the plaintiff recovers an award for damages" and "*does not restrict [DMA's] right of subrogation to a beneficiary's right of recovery only for medical expenses*," regardless of "whether a settlement [on behalf of a Medicaid beneficiary compensates] the plaintiff for medical expenses." *Ezell*, 175 N.C. App. at 64, 623 S.E.2d at 84 (emphasis added). (App. 88) The opinion did not address the federal anti-lien provisions.

4. *The North Carolina Supreme Court's ruling in Andrews.*

In the North Carolina Supreme Court's ruling in the instant case, the Court interpreted the same statutory provision addressed in *Ezell*, but reaching the opposite conclusion: namely that the N.C. Gen.Stat. § 108A-57 was an alternative mechanism to determine the amount of medical expenses in absence of an allocation. (App. 7-10) According to the Court, North Carolina employs an "alternative statutory procedure" to "define" the portion of the settlement which is attributable to medical expenses:

> Rather than requiring a specific determination of the medical expense portion of a settlement, North Carolina employs an alternative statutory procedure that we believe is permitted by *Ahlborn*. *See Ahlborn*, 547 U.S. at 288 n. 18, 126 S.Ct. at 1765 n. 18, 164 L.Ed.2d at 476 n. 18. ***Our state law defines "the portion of the settlement that represents payment for medical expenses" as the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery, limiting the State's reimbursement to the portion so designated.*** See N.C.G.S. § 108A-57(a); see also *Ahlborn*, 547 U.S. at 282, 126 S.Ct. at 1762, 164 L.Ed.2d at 472-73. The one-third limitation of section 108A-57(a) thus comports with *Ahlborn* by providing a reasonable method for determining the State's medical

> reimbursements, which it is required to seek in accordance with federal Medicaid law. See 42 U.S.C. § 1396a (25)(A)-(B) (2000).

(App. 8-9) (emphasis added). Just a little more than two years earlier, the Court had held that this same statute entitled DMA to full reimbursement, and "*does not restrict [DMA's] right of subrogation to a beneficiary's right of recovery only for medical expenses*," *Ezell*, 175 N.C. App. at 64, 623 S.E.2d at 84 (emphasis added). (App 88)

In her dissenting opinion, Justice Hudson points out that the North Carolina General Assembly was clearly not considering how it might define the medical expenses portion of the beneficiary's recovery, as the statute pre-dated *Ahlborn*. (App. 18). She further noted,

> [A]pplication of the bright-line rule articulated by the majority in a case like this one, in which there has been no allocation, could allow precisely the result that is explicitly barred by *Ahlborn*. In fact, this would be the outcome with any settlement in which the amount actually paid by the Division of Medical Assistance (DMA) is greater than the amount of the settlement designated for medical expenses, but less than the one-third cap specified in N.C.G.S. §108A-57(a).

Id.

Defining the pro rata portion of every settlement which represents recovery for past medical expenses as the actual amount up to one-third —or any other arbitrary fraction— does not satisfy the standards set forth by this Court in *Ahlborn*. As noted by Justice Hudson writing for the dissent:

> These statements [by the *Ahlborn* Court] broadly prohibit a state's claim to reimbursement from any funds not earmarked solely for medical expenses under any circumstances. Accordingly to the extent that the terms of a settlement are unclear as to the portion designed for medical expenses, the *Ahlborn* analysis required states to fashion a method to make those determinations and protect their right to reimbursement, for example, 'by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.' [citation omitted] Simply put, an indispensable step in calculating the amount of a State's right to reimbursement for medical expenses is establishing how much of a third-party settlement has been allocated to the medical expenses of the plaintiff-beneficiary.

(App. 17)

Justice Hudson proposed a hypothetical example[8] to illustrate this distinction. Assume a settlement in a

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[8] Actual numbers from the *Andrews* settlement were not used because the settlement agreements were under seal. (App. 18, FN 2)

case for $2,000,000.00 where a Medicaid beneficiary has damages totaling $5 million dollars which include:

> $ 500,000 in past medical expenses paid by DMA
> $1,000,000 in future medical expenses
> $1,500,000 in pain and suffering
> $2,000,000 in lost future earnings
> $5,000,000 total damages

(App. 18-20) Under the majority's holding and application of N.C. Gen.Stat. § 108A-57(a), DMA would be entitled to $500,000 of the settlement, *i.e.* its full reimbursement because $500,000 does not exceed one-third of the gross settlement amount. *Id.* However, under the *Ahlborn* formula, DMA would recover 10% or $200,000 of the settlement, with the balance being for future medical expenses (20% or $400,000), pain and suffering ($600,000 or 30%), and lost earnings ($480,000 or 40%). (App. 19)

Under Justice Hudson's example, DMA's lien would unlawfully exceed the portion attributable to medical expenses by $300,000, as this Court has clearly held that Federal Medicaid law does not authorize a lien on settlements which exceed the pro rata portion designated as reimbursement for medical payments made. *Ahlborn* at 292, 126 S.Ct. at 1767, 164 L.Ed.2d at 479. (App. 75-76) As Justice Hudson concluded, "when the settlement proceeds have not been so allocated, the only way to insure that the application of the statute complies with *Ahlborn* is to provide for such an allocation of the settlement proceeds." (App. 24-25)

B. *Certiorari is Appropriate Because of a Conflict Between the States as to Whether Ahlborn Requires Amendment of Statutes Which Employ a Statutory Cap, or Whether Such States May Utilize Such Caps Without Permitting a Medicaid Beneficiary the Opportunity to Show that Some Other Amount is Appropriate.*

North Carolina and at least several other states, such as Iowa, Hawaii, Florida, and Georgia,[9] continue to allow full recovery or allow full recovery up to a specified percentage. Other states, such as California, Nevada, Pennsylvania, and Oklahoma, have amended their statutes so as to bring their states into compliance with this Court's ruling in *Ahlborn*. Thus, the legislative response to *Ahlborn* has been inconsistent.

1. *North Carolina and Several Other States Continue to Employ Statutes which Fail to Limit Medicaid Recovery to Medical Expenses.*

In *dicta*, this Court in *Ahlborn* granted the states some potential flexibility to fashion an allocation process:

> [S]ome States have adopted special rules and procedures for allocating tort settlements . . .

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[9] Some states whose statutes fail to provide for an allocation of settlement proceeds have not yet repealed those statutes, but are in the process of amending them to address this particular issue. *See, e.g.*, MCA 53-2-612.

> Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.

Ahlborn, 547 U.S. at 288 n. 18, 126 S.Ct. at 1765 n. 18, 164 L.Ed2d at 476 n. 18. (App 70). The *amicus* brief which is cited in footnote 18 of the *Ahlborn* opinion actually refers to the possibility of states establishing procedures for judicial hearings to determine appropriate allocations in the absence of agreement (which is the very relief which had been requested by Petitioner herein). *See, id.*; *Brief of the Association of Trial Lawyers of America*, 2006 WL 139217 at *20-21. However, the majority in the opinion below nonetheless relied on this *dicta* in *Ahlborn* and held that North Carolina's scheme of allowing full recovery by DMA up to one-third of the tort recovery was permissible "statutory alternative" under *Ahlborn*, and has applied the statute as a conclusive presumption that DMA is entitled to full recovery of past medical expenses up to a cap of one-third. (App. 8-9)

At least one other state also employs a similar mechanism in violation of *Ahlborn*. Iowa's statute provides as follows:

> If a recipient of assistance through the medical assistance program incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim upon which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the

> lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the recipient. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the recipient. An attorney acting on behalf of a recipient of medical assistance for the purpose of enforcing a claim upon which the department has a lien shall not collect from the recipient any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this section.

I.C.A. §249A.6. Thus, Iowa's statute provides that after deduction of attorneys' fees and costs, and after the recipient obtains a third, the department's lien shall be paid in full or up to the remaining amount. *Id.* It does not appear that there is any case law interpreting Iowa's statute in the wake of *Ahlborn*.

Georgia's, Hawaii's and Florida's pre-*Ahlborn* statutes provide that the Medicaid is entitled to reimbursement of the full amount actually paid by the Department from a Medicaid recipient's recovery from a third party tortfeasor. Ga. Code Ann. §49-4-149(d); H.R.S. §346-37(c) and (d); F.S.A. §409.910(1), F.S.A. §409.910(4); F.S.A. §409.910(6)(a)[10]. These provisions have not been amended or repealed to address *Ahlborn*.

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[10] This statute was addressed by a Florida court after *Ahlborn*, but no mention was made of the effect of *Ahlborn* on

(Cont'd)

2. *California has Amended Its Statutory Cap Scheme to Bring that State into Compliance with the Federal Anti-Lien Laws and this Court's Decision in Ahlborn.*

Prior to this Court's decision in *Ahlborn*, California's statutory scheme for enforcement of Medicaid liens employed a percentage cap similar to that of North Carolina. Unlike North Carolina, California amended its statute following *Ahlborn* to eliminate those caps and bring its law into compliance with federal law as enunciated by *Ahlborn*. See West's Ann.Cal.Welf. & Inst.Code § 14124.76, 78 (effective August 24, 2007) (Appendix L).

The California statute in place prior to *Ahlborn* had capped Medicaid reimbursement at one-half of the total recovery after deducting various costs and thus employed a mechanism similar to that employed by North Carolina currently. The prior version of §14124.78 provided that:

> the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the [Department's] claim for reimbursement of the reasonable value of benefits provided and any lien filed

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(Cont'd)

the enforceability of the statute, and in fact the court affirmed that Medicaid was entitled to full reimbursement without an allocation. *Ross v. Agency for Health Care Administration*, 947 So.2d 457 (2006), *rehearing denied* (2007).

> pursuant thereto, but in no event shall the [Department's] claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees,[11] litigation costs, and medical expenses relating to the injury paid for by the beneficiary.

West's Ann.Cal.Welf. & Inst.Code § 14124.78 (2006). The new text provides:

> Notwithstanding any other provision of law, in no event shall the director recover more than the beneficiary recovers after deducting, from the settlement judgment, or award, attorney's fees and litigation costs paid for by the beneficiary. If the director's recovery is determined under this section, the reductions in subdivision (d) of Section 14124.72 shall not apply.

(App. 167) California further amended its Medicaid statutes in August of 2007 to provide that:

> (a) No settlement, judgment, or award in any action or claim by a beneficiary to recover damages for injuries, where the director has an interest, shall be deemed final or satisfied

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[11] In contrast to California's prior statute, North Carolina's statute does not provide for deduction of attorneys' fees. Accordingly, Medicaid receives full reimbursement for its past medical expenses up to one-third of the recovery from the tortfeasor, and 100% of the litigation expense is borne by the recipient.

without first giving the director notice and a reasonable opportunity to perfect and to satisfy the director's lien. Recovery of the director's lien from an injured beneficiary's action or claim is limited to that portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. All reasonable efforts shall be made to obtain the director's advance agreement to a determination as to what portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided of behalf on the beneficiary. Absent the director's advance agreement as to what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary, the matter shall be submitted to a court for decision. Either the director or the beneficiary may seek resolution of the dispute by filing a motion, which shall be subject to regular law and motion procedures. In determining what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary and as to what the appropriate reimbursement amount to the director should be, the court shall be guided by the United States Supreme Court decision in *Arkansas Department of Health and Human Services*

v. Ahlborn (2006) 547 U.S. 268 and other relevant statutory and case law.

West's Ann.Cal.Welf. & Inst.Code § 14124.76 (Effective August 24, 2007). (App 164-166)

Thus, in contrast to North Carolina, California's legislative quickly recognized that a 50% cap was not in compliance with this Court's ruling in *Ahlborn*, and took prompt steps to amend the statutes to eliminate the cap and provide for an allocation method.[12]

3. *Pennsylvania's Amendments Following Ahlborn Retained a Statutory Cap, but Only as a Rebuttable Presumption.*

Pennsylvania has taken yet another approach to compliance. Like North Carolina, the Pennsylvania statute assumes that Medicaid is entitled to a specific portion of recoveries (there, one-half). (Appendix K) Unlike North Carolina, however, Pennsylvania recognizes that there will be occasions when factual situations will result in allocations which run afoul of *Ahlborn*. (*Id.*) Pennsylvania's statutory scheme allows a plaintiff to seek an alternative allocation limiting the reimbursement portion of the recovery, although requires that its department of public welfare have a

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[12] This Court's decision in *Ahlborn* and the prompt action taken by California's legislation, however, did not stop California's Department of Medical Assistance from thereafter continuing to try and obtain full recovery without an allocation of settlement proceeds. *Bolanos v. Superior Court*, 169 Cal. App. 4th 744, 87 Cal Rptr. 3d 174 (2008). (This case is discussed further below).

right to be heard. *See* 62 P.S. § 1409 and 62 P.S. §1409.1. (App 150-163)

4. *Oklahoma amended its statutes to Employ a Rebuttable Presumption.*

Similarly, Oklahoma amended its statute November 1, 2007 to provide that its lien extends to the entire settlement "***unless*** a more limited allocation of damages to medical expenses is shown by clear and convincing evidence." 63 Ok.St. Ann. § 5051.1D.(1)(d) (2007). Prior to that time, Oklahoma, like North Carolina, permitted only a flat statutory cap. 63 Ok.St. Ann. § 5051.1D.(1) (2005).

5. *Nevada Rejected a Statutory Cap and Requires a Hearing.*

Nevada specifically considered application of a one-third cap. (Minutes of Health and Human Services Committee 5/2/2007 considering Senate Bill 529 2007). (Appendix M) Nevada chose to reject that approach and instead amended its statutes to require that specific and detailed notice of any hearing on recovery be given to the department in order for it to intervene and be heard. See N.R.S. 422.293 et seq. (2007).

C. *Certiorari is Appropriate Because a Substantial Conflict Exists between the North Carolina Decisions in Andrews and Ezell and Decisions of Several Other State Courts.*

1. *Judicial Decisions of the State of New York.*

New York courts have reached somewhat varying results in different cases in attempting to apply *Ahlborn*. These decisions were summarized by the New York Supreme Court-Queens in *Wright v. New York Hospital Center of Queens*, 2007 WL 4229216 (2007).

For example, in *Lugo v. Beth Israel Med. Ctr.* 13 Misc. 3d 681, 819 N.Y.S. 2d. 892 (2006), the Court held that it had the power to limit Medicaid reimbursement to past medical expenses and conduct a hearing to allocate the medical costs in the settlement. The Court in *Lugo* recognized that it was not required to use the formula outlined in *Ahlborn*. *Id.*, 13 Misc. 3d at 687-89, 819 N.Y.S. 2d at 896-98. The Court instead looked at five factors to determine the true value of the case: 1) the extent of injuries, 2) whether the plaintiff needs future care, therapy or supervision, 3) the likely future duration of that care, 4) the documents utilized to establish plaintiff's injuries and 5) decisions involving jury awards for similarly situated plaintiffs. 13 Misc. 3d at 688-89, 819 N.Y.S. 2d at 897-98.

In *Harris v. The City of New York*, 16 Misc. 3d 674, 2007 WL 1674337 (N.Y. Supp. 2007), a hearing was ordered to determine the proper allocation.

In *Wright*, no stipulation was made by the parties as to the total value of the case and they were permitted to submit evidence of such value. The Court reached a determination of value based on that evidence and then used an *Ahlborn*-type allocation formula taking into account the future care needs of the seriously disabled plaintiff.

Collectively these cases in effect overruled the leading pre-*Ahlborn* New York cases of *Gold v. United Health Services Hospitals, Inc.* 95 NY2d. 683 (2001) and *Crichcio v. Pennisi*, 90 N.Y. 2d 296 (1997) which allowed DSDS to satisfy its liens first from personal injury settlements.

2. *Judicial Decisions of the State of Idaho.*

Idaho continues to employ its pre-*Ahlborn* statute, which has a presumption that Medicaid gets paid first and in full if there is enough money to do so:

> If a settlement or judgment is received by the [Medicaid] recipient without delineating what portion of the settlement or judgment is in payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the recipient in an amount equal to the expenditure for medical assistance benefits paid by the department as a result of the occurrence giving rise to the payment or payments to the recipient.

I.C. 56-209b(6). The Idaho Court noted that this statute, unlike the Arkansas statute, was not an automatic assignment of the settlement to the State, but rather was a statutory framework for determining how to apportion an unallocated settlement. *Idaho Dep't of Health and Welfare v. Hudelson*, 146 Idaho 439, 196 P.3d 905, 911 (2008). In light of *Ahlborn*, the Court interpreted Idaho's statute as a *rebuttable* presumption, and permitted some other allocation by agreement (which must include the Department) or pursuant to a hearing. *Id.*, 196 P.3d at 912. In its instructions upon remand, the Court specifically noted that "if the Court determines that the presumption has been rebutted by the recipient, the "*Ahlborn* Formula" may be used by the court in determining an appropriate allocation." *Id.*

3. *Judicial Decisions of the State of California.*

The California Court of Appeals had an opportunity to consider and apply the statutory revisions made following *Ahlborn* in *Bolanos v. Superior Court*, 169 Cal. App. 4th 744, 87 Cal Rptr. 3d 174 (2008). There, as here, the Court was dealing with a settlement for a severely disabled minor[13] which did not make an allocation for specific types of damages. There, too, the Petitioner made a motion for a hearing to determine which portion of the settlement proceeds were properly allocable to the State's claim for reimbursement of medical

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[13] The Court noted that in cases involving catastrophic injuries to children, settlements are not necessarily driven by past medical expenses, as the cost of future medical expenses which may extend over a lifetime are the largest factors in such settlements. 69 Cal.App.4th at 755, 87 Cal.Rptr.3d at 181.

expenses. Although the motion was filed after the effective date of California's "*Ahlborn* Amendments," the Director nonetheless opposed the motion and took the position that the recipient's total amount of damages was "not relevant" and that the Department was only required to reduce the claim for reimbursement by 25% for attorneys' fees pursuant to California's statute. *Bolanos*, 169 Cal.App.4th at 750, 87 Cal.Rptr.3d at 178. The trial court sided with the Department, and denied the recipient's motion for a hearing on the allocation. *Id.*

In overturning the trial court's denial of the motion for an allocation hearing, the Court of Appeals stated:

> The trial court took note of *Ahlborn*, but it interpreted this decision to be limited to the holding that the state could not recover Medicaid benefits that were not attributable to medical expenses. While this is correct as far as it goes, it is also true that *Ahlborn* went on to reject the contention that the entire settlement was subject to the state's claim for reimbursement, holding that "the State's assigned rights extend only to recovery of medical care" [citation omitted]As we discuss below, this requires a determination of what portion of the settlement is attributable to medical expenses. The trial court did not take account of this further aspect of *Ahlborn*; in essence, we granted the petition to correct this error.

Bolanos, 169 Cal.App.4th at 750, 87 Cal.Rptr.3d at 178.

In its discussion, the California Court notes that the *Ahlborn* "formula" is not the only method for determining an appropriate allocation formula, but somehow this allocation must be addressed:

> "This is not to say that the *Ahlborn* formula is the only one to be followed; there is nothing in that decision that compels this. What matters is that the past medical expenses are distinguished in the settlement from other damages on the basis of a rational approach; . . . .
>
> We agree that *Ahlborn* itself does not require the application of the precise formula used in that case although we do not think this approach, which has the Supreme Court's approval should be abandoned lightly. . . . We [do not] agree that *Ahlborn* is of no consequence when it comes to a settlement that has not been allocated between past medical expenses and other damages.

169 Cal.App.4th at 754, 87 Cal.Rptr.3d at 181.

4. *The Decisions of the North Carolina Courts in Ezell and Andrews are in Conflict with the Decisions in Other States.*

North Carolina's interpretation of the duties under *Ahlborn* and its interpretation of the N.C. Gen.Stat. § 108A-57(a) as a non-rebuttable presumption providing for full Medicaid recovery up to a one-third cap, are in

conflict with the decisions of other jurisdictions. As discussed above, a number of other states have either enacted legislative amendments to bring their statutes into compliance with *Ahlborn*, or have judicially engrafted procedures which ensure that a Medicaid recipient is given the opportunity to have a hearing or agreement to determine the allocation of medical expenses versus other types of expenses.

D. *Certiorari is Appropriate Because the North Carolina Supreme Court's Interpretation of N.C. Gen. Stat. §108A-57(a) is an Unconstitutional Impairment of the Contract Clause of the United States Constitution.*

By statutorily determining that one-third of all third party settlements represent payment for past medical expenses, the North Carolina law impairs the ability of parties to enter into enforceable settlement contracts which allocate some lesser percentage of the funds to payment for past medical expenses. As expressed by Justice Hudson in the *Andrews* dissent, such an impairment violates the Contracts Clause of the United States Constitution. (App. 21-22)

The "Contracts Clause" as the provision is commonly known, provides that no state shall pass any law "impairing the Obligation of Contract." U.S.C.A. Const. Art. I § 10, cl. 1. In conducting a Contracts Clause analysis, the Court must first determine whether a state's law substantially impairs a contractual relationship. *General Motors Corp. v. Romein*, 503 U.S. 181, 186, 112 S.Ct. 1105, 1109-1110 (U.S.Mich.,1992)

"This inquiry has three components: whether there is a contractual relationship, whether a change in law impairs that contractual relationship, and whether the impairment is substantial." *Id.*

As Justice Hudson explained in the Dissent below:

> [T]he majority's interpretation could lead to the conclusion that N.C.G.S. § 108A-57(a) violates the Contract Clause of the United States Constitution by overriding the intentions of parties to private contract. *See* U.S. Const. art. I, § 10, cl. 1 ("No state shall ... pass any . . . law impairing the obligation of contracts. . . ."); *Adair v. Orrell's Mut. Burial Ass'n*, 284 N.C. 534, 538, 201 S.E.2d 905, 908 ("Any law which enlarges, abridges or changes the intention of the parties as indicated by the provisions of a contract necessarily impairs the contract. . . .") (citations omitted), *appeal dismissed*, 417 U.S. 927, 94 S.Ct. 2637, 41 L.Ed.2d 231 (1974).
>
> I recognize that such impairment is sometimes permissible "to protect the general welfare of its citizens, so long as such impairment is reasonable and necessary to serve an important public purpose." *Bailey v. State*, 348 N.C. 130, 151, 500 S.E.2d 54, 66 (1998) (citing *U.S. Trust Co. of N.Y. v. New Jersey*, 431 U.S. 1, 25-26, 97 S.Ct. 1505, 52 L.Ed.2d 92, 111-12 (1977)). However, " 'a State is not free to impose a drastic impairment when an evident and more moderate course

> would serve its purposes equally well.' " *Id.* at 152, 500 S.E.2d at 67 (quoting *U.S. Trust*, 431 U.S. at 31, 97 S.Ct. at 1522, 52 L.Ed.2d at 115). Moreover, " '[i]n applying this standard, . . . complete deference to a legislative assessment of reasonableness and necessity is not appropriate because the State's self-interest is at stake.' " *Id.* at 151, 500 S.E.2d at 66 (quoting *U.S. Trust*, 431 U.S. at 25-26, 97 S.Ct. at 1519, 52 L.Ed.2d at 112 (alteration in original)).

(App. 21-22)

Thus, the North Carolina Supreme Court's interpretation of N.C. Gen.Stat. § 108A-57(a) as a "blanket determination that the full one-third of any settlement amount between a plaintiff and a third party is for medical expenses" (*See, dissenting opinion*, App. 21) violates the Contracts Clause in that it prevents parties from contractually agreeing otherwise, even if the contractual amount reflects the true and actual allocation of damages in the case.

This impairment of the ability of parties to a personal injury settlement to allocate categories of damages is substantial in that it violates the parties' intentions and expectations related to the terms of the settlement agreement and can impact considerations outside of Medicaid reimbursement, including taxation. "The severity of the impairment is said to increase the level of scrutiny to which the legislation will be subjected. Total destruction of contractual expectations is not necessary for a finding of substantial impairment."

Energy Reserves Group, Inc. v. Kansas Power and Light Co., 459 U.S. 400, 411, 103 S.Ct. 697, 704 (U.S.Kan.,1983) (internal citations omitted). Because the allocation provision of a settlement agreement is a deliberately negotiated term, a change in that term (to an automatic one-third medical expenses in all cases) is a substantial impairment of contractual expectations of the parties to that contract.

CONCLUSION

For the reasons and based on the authorities set forth above, the Petitioner respectfully requests that the petition for certiorari be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE NORTH CAROLINA SUPREME COURT DECIDED DECEMBER 12, 2008

SUPREME COURT OF NORTH CAROLINA

No. 57A07-2.

Dec. 12, 2008.

Katelyn ANDREWS, a minor, Through her Guardian ad Litem, David ANDREWS; and David Andrews and Andrea Andrews, individually

v.

Vanessa P. HAYGOOD, M.D., individually; Central Carolina Obstetrics and Gynecology, P.A., a North Carolina Corporation; The Women's Hospital of Greensboro, a North Carolina Not-for-Profit Corporation; Kim Richey, R.N., individually; and Jennifer Daley, R.N., individually

v.

North Carolina Department of Health and Human Services, Division of Medical Assistance, Intervenor.

NEWBY, Justice.

This case presents the question of whether the statutory framework governing the State's subrogation claim for medical expenses on a Medicaid recipient's tort claim settlement complies with federal Medicaid law as

interpreted by the Supreme Court of the United States in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006). Because *Ahlborn* does not mandate a specific method for determining the medical expense portion of a plaintiff's settlement, we uphold North Carolina's reasonable statutory scheme and accordingly affirm the Court of Appeals.

Plaintiff Katelyn Andrews brought suit against defendants, alleging medical malpractice and seeking recovery for injuries she sustained at birth. The parties entered into confidential settlement agreements and established a settlement account for the proceeds. Because Katelyn is a North Carolina Medicaid recipient, the North Carolina Division of Medical Assistance ("DMA") sought to recover from the account the amount it paid for her medical expenses, $1,046,681.94. The trial court determined the DMA has subrogation rights to the entire amount of the settlement, limited by the statutory provision that only one-third of a recovery is subject to subrogation. N.C.G.S. § 108A-57(a) (2005). Because the amount expended by the DMA was less than one-third of the settlement, the trial court ordered full reimbursement. The trustee of the settlement account appealed.

The Court of Appeals affirmed the trial court's order based on our prior decision in *Ezell v. Grace Hospital, Inc.*, 360 N.C. 529, 631 S.E.2d 131 (2006), *rev'g per curiam for reasons stated in the dissenting opinion*, 175 N.C.App. 56, 623 S.E.2d 79 (2005), *reh'g denied*, 361

N.C. 180, 641 S.E.2d 4 (2006). *Andrews v. Haygood*, __ N.C.App. __, __, 655 S.E.2d 440, 444 (2008). However, a dissent questioned the majority's reliance on *Ezell* because in reversing the Court of Appeals, we did not specifically address the applicability of the holding in *Ahlborn* to the issues in *Ezell*. *Id.* at __, 655 S.E.2d at 444-45 (Wynn, J., dissenting).

Based on the dissent, the trustee appealed to this Court, and we granted review of additional issues arising from the trial court's denial of requests for an evidentiary allocation hearing and for a delay in resolution of the case until a third party could be joined. The trustee contends that absent an agreement between the parties, federal law requires a judicial determination of the portion of a tort claim settlement that represents the recovery of medical expenses. In response, the DMA contends the statutory one-third limiting provision complies with *Ahlborn's* interpretation of federal Medicaid law. The DMA thus argues that judicial apportionment of medical expenses from the settlement is not required. We agree.

Medicaid is a cooperative program that provides federal and state medical care funding for certain individuals who are unable to afford their own medical costs. *See Ahlborn*, 547 U.S. at 275, 126 S.Ct. at 1758, 164 L.Ed.2d at 468. Participating states are required by federal law to "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan" and to "seek reimbursement for [medical] assistance [made available

on behalf of a recipient] to the extent of such legal liability." 42 U.S.C. § 1396a(a)(25)(A)-(B) (2000). State laws control the administration of the program, including the method by which a state may seek reimbursement for prior Medicaid assistance. *See Ahlborn*, 547 U.S. at 275-77, 126 S.Ct. at 1758-59, 164 L.Ed.2d at 468-70. State laws, however, must comply with federal Medicaid law. *Id.*

The Supreme Court of the United States addressed the operation of a state's Medicaid reimbursement statute in *Ahlborn*, in which the Court was asked to determine whether the Arkansas Department of Health and Human Services ("ADHS") could claim a statutory lien on a settlement for more than the portion that by stipulation represented the recovery of medical expenses. *Ahlborn*, 547 U.S. at 279-80, 126 S.Ct. at 1760-61, 164 L.Ed.2d at 470-71. The Arkansas statutes in question[1] allowed total reimbursement to ADHS for all

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1. The pertinent sections of the Arkansas Code read:

> As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services *to the full extent* of any amount which may be paid by Medicaid for the benefit of the applicant.

Ark.Code. Ann. § 20-77-307(a) (2001) (emphasis added). Accordingly, "when medical assistance benefits are provided (Cont'd)

previous medical payments made on the plaintiff's behalf. *Id.* at 278-79, 126 S.Ct. at 1759-60, 164 L.Ed.2d at 470-71. Ahlborn, a Medicaid recipient, challenged the statute because it permitted reimbursement from settlement proceeds recovered for damages other than medical expenses. *Id.* at 274, 126 S.Ct. at 1757-58, 164 L.Ed.2d at 468. In her suit against the alleged tortfeasors, she sought compensation for medical expenses, pain and suffering, lost wages, and permanent impairment of her future wage-earning ability. *Id.* at 273, 126 S.Ct. at 1757, 164 L.Ed.2d at 467. After the parties settled for $550,000, ADHS asserted a lien against the settlement for $215,645.30–the total amount of prior payments made by ADHS for Ahlborn's medical care. *Id.* at 274, 126 S.Ct. at 1757, 164 L.Ed.2d at 468. Ahlborn challenged the lien, alleging it violated federal Medicaid law "insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses." *Id.*

Before trial, Ahlborn and ADHS stipulated to several facts. *Id.* at 274, 126 S.Ct. at 1757-58, 164 L.Ed.2d at 468. The reasonable value of Ahlborn's claim, absent any consideration of liability, was specified to be approximately $3,040,708.18. *Id.* The parties agreed the

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(Cont'd)

. . . to a . . . recipient because of injury, disease, or disability for which another person is liable . . . the Department of Human Services shall have a right to recover from the person *the cost of benefits so provided.*" *Id.* § 20-77-301(a) (2001) (emphasis added).

settlement amount of $550,000 represented approximately one-sixth of the estimated total damages. *Id.* ADHS further stipulated that if Ahlborn's construction of the Arkansas statute were correct, ADHS would only be entitled to reimbursement for one-sixth of the total past medical payments, or $35,581. 47. *Id.*

The Supreme Court of the United States determined that ADHS was entitled to recover $35,581.47, the portion of the settlement stipulated to represent Ahlborn's recovery of medical expenses. *Id.* at 292, 126 S.Ct. at 1767, 164 L.Ed.2d at 479. The Court held: "Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47. . . . Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion." *Id. Ahlborn* thus controls when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement. In those cases, the State may not receive reimbursement in excess of the portion so designated.

The *Ahlborn* holding, limited by the parties' stipulations, did not require a specific method for determining the portion of a settlement that represents the recovery of medical expenses. *See id.* at 288, 126 S.Ct. at 1765, 164 L.Ed.2d at 476. The Court recognized that "some States have adopted special rules and procedures for allocating tort settlements" under certain circumstances, but ultimately "express[ed] no view on the matter" and "le[ft] open the possibility that

such rules and procedures might be employed to meet concerns about settlement manipulation." *Id.* at 288 n. 18, 126 S.Ct. at 1765 n. 18, 164 L.Ed.2d at 476 n. 18. *Ahlborn* thus does not mandate a judicial determination of the portion of a settlement from which the State may be reimbursed for prior medical expenditures. Instead, the Supreme Court left to the States the decision on the measures to employ in the operation of their Medicaid programs. *Id.*

Our General Assembly created a statutory method to determine the amount of the State's reimbursements for prior medical payments. North Carolina law provides that Medicaid recipients are "deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise to which [the recipient] may be entitled." N.C.G.S. § 108A-59(a) (2005). Implementation of the recipient's statutory assignment is governed by section 108A-57(a) of our General Statutes:

> Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State . . . shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance . . . against any person. . . . Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with . . . a third party . . . distribute to the Department the amount of assistance paid by the Department . . . *but*

> *the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.*

Id. § 108A-57(a) (2005) (emphasis added). While encouraging complete recovery for past medical payments, the North Carolina statute allows total reimbursement to the State only when "the amount of assistance" previously paid for medical expenses is one-third of the plaintiff's settlement or less. *Id.* If the amount of the State's claim exceeds one-third of the recovery, our statute limits reimbursement to one-third of the settlement. *Id.* Section 108A-57(a) thus prevents excessive depletion of a plaintiff's recovery to satisfy the State's reimbursement lien. Nonetheless, plaintiffs are free to negotiate a settlement with the State for a lien amount less than that required by our statutes.

Rather than requiring a specific determination of the medical expense portion of a settlement, North Carolina employs an alternative statutory procedure that we believe is permitted by *Ahlborn*. *See Ahlborn*, 547 U.S. at 288 n. 18, 126 S.Ct. at 1765 n. 18, 164 L.Ed.2d at 476 n. 18. Our state law defines "the portion of the settlement that represents payment for medical expenses" as the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery, limiting the State's reimbursement to the portion so designated. *See* N.C.G.S. § 108A-57(a); *see also Ahlborn*, 547 U.S. at 282, 126 S.Ct. at 1762, 164 L.Ed.2d at 472-73. The one-third limitation of section 108A-57(a) thus comports with *Ahlborn* by providing a

reasonable method for determining the State's medical reimbursements, which it is required to seek in accordance with federal Medicaid law. *See* 42 U.S.C. § 1396a(25)(A)-(B) (2000).

This statutory scheme protects plaintiffs' interests while promoting efficiency in Medicaid reimbursement cases throughout North Carolina. In enacting our statute, the General Assembly may have considered factors such as the strain on resources to send State employees across North Carolina to participate in evidentiary allocation hearings each time a Medicaid recipient recovers from a third party. Likewise, the legislature may have found it important that a case-by-case determination of the medical expense portion of settlements could lead to variable results and increased litigation due to inconsistency in outcomes. Certainly, "[w]eighing these and other public policy considerations is the province of our General Assembly, *605 not this Court." *Shaw v. U.S. Airways, Inc.*, 362 N.C. 457, 463, 665 S.E.2d 449, 453 (2008).

We accord a presumption of validity to the General Statutes of this State. *See, e.g., Wayne Cty. Citizens Ass'n for Better Tax Control v. Wayne Cty. Bd. of Comm'rs*, 328 N.C. 24, 29, 399 S.E.2d 311, 314-15 (1991); *Ramsey v. N.C. Veterans Comm'n*, 261 N.C. 645, 647, 135 S.E.2d 659, 661 (1964). When the General Assembly enacts a statute after examining its legal and public policy implications, it is not the province of this Court to substitute its judgment for that of our legislature. *See, e.g., Shaw*, 362 N.C. at 463, 665 S.E.2d at 453;

Newlin v. Gill, 293 N.C. 348, 350-52, 237 S.E.2d 819, 821-22 (1977); *see also Bockweg v. Anderson,* 328 N.C. 436, 451-52, 402 S.E.2d 627, 636-37 (1991) (Martin, J., dissenting). As we previously did in *Ezell,* we have again reviewed section 108A-57(a) and find it to be a reasonable framework that comports with the requirements of federal Medicaid law as interpreted by *Ahlborn.* If the General Assembly desires a different result in these cases it may amend the statutes accordingly.

We therefore affirm the Court of Appeals' holding that the trial court did not err in subrogating the plaintiff's settlement proceeds to the DMA, subject to the one-third statutory limitation. Because our resolution of this issue is dispositive, we need not address the requested joinder of United Healthcare and the Court of Appeals decision as to that issue remains undisturbed.

AFFIRMED; DISCRETIONARY REVIEW IMPROVIDENTLY ALLOWED IN PART.

Justice HUDSON dissenting.

Although I agree with the majority that "[*Arkansas Department of Health & Human Services v.*] *Ahlborn* does not mandate a specific method for determining the medical expense portion of a plaintiff's settlement," the United States Supreme Court nevertheless did explicitly hold in *Ahlborn* that a State may not violate the anti-lien provisions of 42 U.S.C. §§ 1396a(a)(18) and 1396p by requiring a Medicaid recipient to reimburse it out of settlement funds designated for purposes other than medical care. 547 U.S. 268, 284-85, 126 S.Ct. 1752, 164 L.Ed.2d 459, 474 (2006). The terms of the settlement at issue here provide insufficient detail to allow us to determine whether the application of N.C.G.S. § 108A-57(a) would violate the anti-lien provisions of the federal Medicaid statutes, pursuant to the holding in *Ahlborn.* Because I conclude that we are bound to follow *Ahlborn,* I must respectfully dissent.

As observed by the United States Supreme Court, the federally funded and administered Medicaid program is "a cooperative one," with participating states "compl[ying] with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program" in exchange for the federal funding. *Id.* at 275, 126 S.Ct. at 1758, 164 L.Ed.2d at 468-69. Among these requirements is "that the state agency in charge of Medicaid . . . 'take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan.' " *Id.* at 275,

126 S.Ct. at 1758, 164 L.Ed.2d at 469 (quoting 42 U.S.C. § 1396a(a)(25)(A) (2000) (alteration in original)). Further,

> The [state] agency's obligation extends beyond mere identification, however; "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability."

Id. at 276, 126 S.Ct. at 1758, 164 L.Ed.2d at 469 (quoting 42 U.S.C. § 1396a(a)(25)(B)). The federal Medicaid statutes obligate participating states to enact so-called "assignment laws" to provide for such reimbursement. *Id.* at 276-77, 126 S.Ct. at 1758-59, 164 L.Ed.2d at 469-70 (citing 42 U.S.C. §§ 1396a(a)(25)(H), 1396k(a)).

In enacting section 108A-57(a), our General Assembly fulfilled this requirement while also explicitly limiting the percentage of a settlement that the State could recover through assignment:

> Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, *shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance,* or of the

> beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. The county attorney, or an attorney retained by the county or the State or both, or an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made under this Part shall enforce this section. Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, *but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.*

N.C.G.S. § 108A-57(a) (2005) (emphases added). Moreover, the General Assembly specifically provided that "the provisions of this Part shall be liberally construed in relation to [the federal Social Security Act providing grants to the states for medical assistance] so that the intent to comply with it shall be made effectual." *Id.* § 108A-56 (2005). In my view, the majority's interpretation runs contrary to this directive by risking violations of the federal anti-lien provisions, which would render our State out of compliance with

Medicaid requirements and thereby jeopardize the funding our State receives.

The General Assembly's explicit direction that we defer to the federal provisions as necessary guides our consideration of the interaction of these federal and state statutes. In addition, because this case involves questions of federal statutory law, we are bound by the United States Supreme Court's interpretation of the federal Medicaid statutes. As this Court has stated:

> It is elementary that an act of Congress, in pursuance of the Constitution of the United States, is the supreme law of the land. Constitution of the United States, Article VI, Clause 2. Thus, in case of a conflict between such an act and the law of North Carolina, the act of Congress controls and, so long as it remains in effect, modifies the law of this State and the authority of its courts to render judgment in accordance therewith. It is equally well settled that a decision of the Supreme Court of the United States, construing an act of Congress, is conclusive and binding upon this Court.

R.H. Bouligny, Inc. v. United Steelworkers, 270 N.C. 160, 173-74, 154 S.E.2d 344, 356 (1967). The United States Supreme Court decision in *Ahlborn* directly addresses and determines the question presented by this case, as our state statute is similar to the one at issue in *Ahlborn* and the factual situations are

analogous. Therefore, I conclude that *Ahlborn* is binding upon this Court, and its reasoning and holding compel the conclusion that the application of N.C.G.S. § 108A-57(a) here, without any further determination of how the settlement proceeds were allocated among the different types of damages alleged by plaintiff, would be contrary to federal law.

In delivering the opinion of a unanimous Court in *Ahlborn,* Justice John Paul Stevens framed the issue as follows:

> When a Medicaid recipient in Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs–like pain and suffering, lost wages, and loss of future earnings. The Court of Appeals for the Eight Circuit held that this statutory lien contravened federal law and was therefore unenforceable. Other courts have upheld similar lien provisions. We granted certiorari to resolve the conflict and now affirm.

547 U.S. at 272, 126 S.Ct. at 1756-57, 164 L.Ed.2d at 467 (internal citations omitted). Thus, contrary to the majority's assertion that the *Ahlborn* holding controls only in situations in which there has been "a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement," the Supreme Court in no way rested its analysis on whether a settlement had been so allocated.

Rather, the Supreme Court in *Ahlborn* "express[ed] no view on" how such allocation should be determined "[e]ven in the absence of such a postsettlement agreement," *id.* at 547 at 288 & n. 18, 126 S.Ct. at 1765 & n. 18, 164 L.Ed.2d at 476 & n. 18, emphasizing instead simply that, regardless of how an allocation is made, "the exception carved out by [the anti-lien provisions laid out in 42 U.S.C. §§ 1396a(a)(18) and 1396p] is limited to payments [by the third party to the plaintiff-beneficiary] for medical care. Beyond that, the anti-lien provision applies," *id.* at 284-85, 126 S.Ct. at 1763, 164 L.Ed.2d at 474. Indeed, the Court repeatedly emphasized this point as to "whether [a state agency] can lay claim to more than the portion of [the plaintiff-beneficiary's] settlement that represents medical expenses":

> The text of the federal third-party liability provisions suggests not; it focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party,"

> 42 U.S.C. § 1396k(a)(1)(A) (emphasis added), not rights to payment for, for example, lost wages.

Id. at 280, 126 S.Ct. at 1760-61, 164 L.Ed.2d at 471 (alteration in original). More explicitly, "under the federal statute the State's assigned rights extend only to recovery of payments for medical care." *Id.* at 282, 126 S.Ct. at 1761-62, 164 L.Ed.2d at 472. Likewise, "assignment of the right to compensation for lost wages and other nonmedical damages is nowhere authorized by the federal third-party liability provisions." *Id.* at 286 n. 16, 126 S.Ct. at 1764 n. 16, 164 L.Ed.2d at 475 n. 16.

These statements broadly prohibit a state's claim to reimbursement from any funds not earmarked solely for medical expenses under any circumstances. Accordingly, to the extent that the terms of a settlement are unclear as to the portion designated for medical expenses, the *Ahlborn* analysis requires states to fashion a method to make those determinations and protect their right to reimbursement, for example, "by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Id.* at 288, 126 S.Ct. at 1765, 164 L.Ed.2d at 476. Simply put, an indispensable step in calculating the amount of a State's right to reimbursement for medical expenses is establishing how much of a third-party settlement has been allocated to the medical expenses of the plaintiff-beneficiary.

The majority would hold that in N.C.G.S. § 108A-57(a), the General Assembly attempted to do just that and that the statute "comports with *Ahlborn* by providing a reasonable method for determining the State's medical reimbursements," namely, capping the reimbursement at no more than one-third of a beneficiary's settlement with a third party. However, application of the bright-line rule articulated by the majority in a case like this one, in which there has been no allocation, could allow precisely the result that is explicitly barred by *Ahlborn*. In fact, this would be the outcome with any settlement in which the amount actually paid by the Division of Medical Assistance (DMA) is greater than the amount of the settlement designated for medical expenses, but less than the one-third cap specified in N.C.G.S. § 108A-57(a).

A hypothetical example illustrates this point.[2] Suppose a plaintiff-a past beneficiary of Medicaid assistance-settles with a tortfeasor for $2 million following an automobile accident. She initially alleged damages totaling $5 million, including $500,000 in past medical expenses, $1 million in future medical expenses, $1.5 million in pain and suffering, and $2 million in lost future earnings income. Medicaid, through DMA, paid the full $500,000 in actual past medical costs for the beneficiary's treatment following the accident. Under the majority's holding and application of N.C.G.S. § 108A-57(a), DMA would be entitled to $500,000 of the

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2. Because the settlement agreements here are confidential and held under seal, I use only hypothetical figures.

settlement. However, without knowing more about how the parties allocated the settlement among the different types of damages sought, the amounts might suggest that the parties, as in *Ahlborn*, reached a settlement that prorated the beneficiary's damages, awarding her forty percent of what she sought in each category of damages. In that scenario, of the $2 million settlement, $200,000 would be designated for past medical expenses, $400,000 for future medical expenses, $600,000 for pain and suffering, and $800,000 for lost future earnings income. Awarding the full $500,000 to DMA would thus exceed the $200,000 designated for past medical expenses and clearly violate the explicit holding of *Ahlborn*.

Likewise, N.C.G.S. § 108A-57(a) and the majority opinion make no distinction between past medical expenses paid by DMA that relate directly to the injury that is the basis of the settlement and expenses that were paid for treatment of a preexisting, ongoing condition. For example, in the scenario outlined above, suppose DMA had paid $500,000 in medical costs for the beneficiary, but only $300,000 of that amount related to the automobile accident, with the balance of $200,000 spent on treatment for the beneficiary's leukemia. Under the majority's holding, DMA could still claim the full $500,000 from the beneficiary, as that amount does not exceed the one-third statutory limitation in N.C.G.S. § 108A-57(a)–even though that recovery would include reimbursement for medical expenses totally unrelated to the accident or the settlement. This result, permitted by this Court's earlier holding in *Ezell v. Grace Hospital*,

Inc., 360 N.C. 529, 631 S.E.2d 131, *rev'g per curiam for reasons stated in the dissent* 175 N.C.App. 56, 623 S.E.2d 79 (2005), *reh'g denied*, 361 N.C. 180, 641 S.E.2d 4 (2006), would clearly violate the anti-lien provisions of the federal Medicaid statutes, contrary to the holding of *Ahlborn*. As such, I also believe we should overrule that decision.

Here, as in *Ahlborn*, plaintiff's civil suit sought damages including, but not limited to, past medical expenses paid by Medicaid and others; the complaint also alleged damages for mental and physical pain and anguish, severe and permanent injury, future medical expenses, loss of future earnings, disfigurement and loss of normal use of her body, her parents' expenses for education and life care, and her parents' emotional distress and derivative claims. These claims were settled among all parties, with proceeds held in a single account and no allocations made as to which specific amounts represented damages for which particular type of claim. Nevertheless, the parties clearly intended the settlement to account for all of the different types of damages alleged not just by plaintiff, but also by her parents. The parties concede that the amount of the settlement here allows DMA to be fully reimbursed for the entire $1,046,681.94 it had paid through October 2005 for plaintiff's medical care, without violating the one-third cap of N.C.G.S. § 108A-57(a). However, the lack of stipulation or other determination as to the allocation of the settlement funds among the damages leaves us unable to conclude whether a DMA lien for full reimbursement would impermissibly entitle DMA to an

amount greater than the medical expenses portion of the settlement, as is prohibited by *Ahlborn*.

In addition, the majority misinterprets N.C.G.S. § 108A-57(a) as being the General Assembly's blanket determination that the full one-third of any settlement amount between a plaintiff and a third party is for medical expenses.[3] In my view, that is neither what the

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3. Although neither party has raised the issue of unconstitutional impairment of contract before this Court, I also believe the majority's interpretation could lead to the conclusion that N.C.G.S. § 108A-57(a) violates the Contract Clause of the United States Constitution by overriding the intentions of parties to private contract. *See* U.S. Const. art. I, § 10, cl. 1 ("No state shall . . . pass any . . . law impairing the obligation of contracts. . . ."); *Adair v. Orrell's Mut. Burial Ass'n*, 284 N.C. 534, 538, 201 S.E.2d 905, 908 ("Any law which enlarges, abridges or changes the intention of the parties as indicated by the provisions of a contract necessarily impairs the contract . . . .") (citations omitted), *appeal dismissed*, 417 U.S. 927, 94 S.Ct. 2637, 41 L.Ed.2d 231 (1974).

I recognize that such impairment is sometimes permissible "to protect the general welfare of its citizens, so long as such impairment is reasonable and necessary to serve an important public purpose." *Bailey v. State*, 348 N.C. 130, 151, 500 S.E.2d 54, 66 (1998) (citing *U.S. Trust Co. of N.Y. v. New Jersey*, 431 U.S. 1, 25-26, 97 S.Ct. 1505, 52 L.Ed.2d 92, 111-12 (1977)). However, " 'a State is not free to impose a drastic impairment when an evident and more moderate course would serve its purposes equally well.' " *Id.* at 152, 500 S.E.2d at 67 (quoting *U.S. Trust*, 431 U.S. at 31, 97 S.Ct. at 1522, 52 L.Ed.2d at 115). Moreover, " '[i]n applying this standard, . . . complete deference

(Cont'd)

statute says nor what it does. According to the plain language of the statute, the legislature envisioned both that a beneficiary could have a private attorney representing her in an action against a third party, *see* N.C.G.S. § 108A-57(a) (referring to "[a]ny attorney retained by the beneficiary of the assistance"), and that for most settlements, damages for medical expenses would be prorated among the various providers, *see id.* (requiring the recipient's attorney to "distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered"). Thus, the General Assembly itself recognized that either stipulations by the parties or evidentiary hearings would be necessary to determine the amount of recovery by DMA and others seeking reimbursement for payment of medical expenses. Moreover, as with other lien statutes, *see, e.g.*, N.C.G.S. § 97-10.2(f) (2005) (Workers' Compensation Act), the General Assembly acknowledged that the beneficiary's attorney would likely be entitled to a large percentage of the settlement as a contingent fee; as such, the one-third cap represents a reasonable ceiling on the amount paid to DMA while also ensuring that the beneficiary would still recover a meaningful proportion of the settlement.

(Cont'd)

to a legislative assessment of reasonableness and necessity is not appropriate because the State's self-interest is at stake.' " *Id.* at 151, 500 S.E.2d at 66 (quoting *U.S. Trust*, 431 U.S. at 25-26, 97 S.Ct. at 1519, 52 L.Ed.2d at 112 (alteration in original)).

This reading of the statute is supported by the public policy rationale that underpins the federal requirements for "assignment laws" adopted by the states to seek reimbursement for the Medicaid payments they make. Such assignments prevent "double recovery" by a beneficiary: because the beneficiary is required to repay Medicaid from the medical expenses portion of his settlement with a third-party tortfeasor, he does not keep both the State's money and damages recovered from the tortfeasor. However, both the federal and state statutory schemes rely on the beneficiary-not the State or county–to bring a civil action against the third-party tortfeasor. Indeed, without the beneficiary's action to bring the suit, the State may enjoy no recovery at all for the Medicaid payments it made to the beneficiary as a result of the injury or accident. Thus, the State seeks to encourage beneficiaries to bring such suits. Accordingly, the statute is designed to protect the State's interest in having the suit brought by providing an incentive for the beneficiary to bring the suit–namely, by safeguarding some portion of the settlement for the beneficiary rather than allowing all of the proceeds to be paid to the attorneys and to DMA and other medical lienholders. Without this guarantee of some return, beneficiaries would be unlikely to go through the time and inconvenience associated with pursuing a civil action, and the State or DMA would be left with no recovery at all.

Application of N.C.G.S. § 108A-57(a) in a manner consistent with this rationale likewise comports with the reasoning relied upon by the United States Supreme

Court in *Ahlborn* to ensure that a state Medicaid agency does not "force an assignment of, or place a lien on, any other portion of [the beneficiary's] property" or settlement proceeds designated to compensate a beneficiary for other types of damages. 547 U.S. at 284, 126 S.Ct. at 1763, 164 L.Ed.2d at 474. Specifically, *Ahlborn* compels our State to apply N.C.G.S. § 108A-57(a) in compliance with the following language:

> Federal Medicaid law does not authorize [the state agency] to assert a lien on [a beneficiary's] settlement in an amount exceeding [the pro rata portion designated as reimbursement for medical payments made], and the federal anti-lien provision affirmatively prohibits it from doing so. [The State's] third-party liability provisions are unenforceable insofar as they compel a different conclusion.

Id. at 292, 126 S.Ct. at 1767, 164 L.Ed.2d at 479. Thus, I would not find that N.C.G.S. § 108A-57(a) violates the federal anti-lien provisions on its face, as it could be applied to factual situations in which the parties have stipulated, or an evidentiary hearing has determined, how to allocate the settlement proceeds among medical expenses and other damages. Nevertheless, I conclude that here, when the settlement proceeds have not been so allocated, the only way to ensure that the application

of the statute complies with *Ahlborn* is to provide for such an allocation.[4]

I would therefore reverse the Court of Appeals with instructions to remand to the trial court to hold an evidentiary hearing to ensure that the DMA lien is not applied to settlement proceeds aside from those designated to reimburse medical expenses.

Justices BRADY and TIMMONS-GOODSON join in this dissenting opinion.

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4. As noted by the Supreme Court in *Ahlborn*, the risk of settlement manipulation, also discussed by Judge Steelman in his dissent in *Ezell*, 175 N.C.App. at 65-66, 623 S.E.2d at 85, "can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Ahlborn*, 547 U.S. at 288, 126 S.Ct. at 1765, 164 L.Ed.2d at 476. In addition, the United States Supreme Court disavowed this rationale-that was the basis of Judge Steelman's dissent, which we adopted, 360 N.C. 529, 631 S.E.2d 131-and observed that "there [is] a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others." *Ahlborn*, 547 U.S. at 288, 126 S.Ct. at 1765, 164 L.Ed.2d at 476. For this reason too I would disagree with the majority opinion's conclusion that *Ezell* is still good law.

APPENDIX B — OPINION OF THE NORTH CAROLINA COURT OF APPEALS FILED JANUARY 15, 2008

COURT OF APPEALS OF NORTH CAROLINA

No. COA06-1670.

Jan. 15, 2008.

Katelyn ANDREWS, a minor, Through her Guardian ad Litem, David ANDREWS and David Andrews and Andrea Andrews, Individually, Plaintiffs

v.

Vanessa P. HAYGOOD, M.D., Individually, and Central Carolina Obstetrics and Gynecology, P.A., a North Carolina Corporation, The Women's Hospital of Greensboro, a North Carolina Not for Profit Corporation and Kim Rickey, RN, Individually, and Jennifer Daley, Individually, Defendants

v.

North Carolina Department of Health and Human Services, Division of Medical Assistance, Intervenor.

HUNTER, Judge.

Katelyn Andrews ("Katelyn") was injured at birth. Katelyn, through her Guardian ad Litem, brought suit against her doctors and the hospital at which she was delivered for medical malpractice. Katelyn's parents also

brought suit against the same parties and on the same allegations in their individual capacities, with an additional claim of negligent infliction of emotional distress. Katelyn and her parents ("plaintiffs") eventually entered into settlement agreements with the parties. After the trial court approved the agreements and established a settlement account, Charlie D. Brown ("trustee") was named trustee and the agreements were made confidential upon the trial court's order.

Katelyn is a North Carolina Medicaid recipient due to the injuries she sustained at birth. The North Carolina Division of Medical Assistance ("DMA") therefore moved to intervene. North Carolina, through the DMA, had paid $1,046,681.94 for her medical services through 10 October 2005. Under N.C. Gen.Stat. § 108A-57 (2005), the DMA moved for reimbursement from the settlement account. The trial court granted DMA's motion and ordered that trustee pay the amount requested by DMA. Trustee now appeals to this Court. After careful consideration, we affirm the ruling of the trial court.

Trustee presents the following issues for this Court's review: (1) whether the trial court erred in concluding that our Supreme Court's decision in *Ezell, N.C. Dep't of Health & Human Servs. v. Grace Hosp.*, 360 N.C. 529, 631 S.E.2d 131 (2006), is controlling and the United States Supreme Court's decision in *Arkansas Dep't of HHS v. Ahlborn*, 547 U.S. 268, 126

S.Ct. 1752, 164 L.Ed.2d 459 (2006), is not[1]; (2) whether the trial court erred in finding that the DMA has a "lien" on the settlement account as opposed to a "claim" on it; and (3) whether the trial court erred in finding that the DMA is a "beneficiary" of the settlement account as opposed to a "claimant" of the account.

Because all of trustee's assignments of error relate to the trial court's conclusions of law, we review those decisions *de novo*.[2] *Medina v. Division of Soc. Servs.*, 165 N.C.App. 502, 505, 598 S.E.2d 707, 709 (2004). We now turn to trustee's arguments.

I.

This case involves the application of N.C. Gen.Stat. §§ 108A-57 and 59(a) (2005). Under section 59(a), Medicaid recipients, by accepting medical assistance, are "deemed to have made an assignment to the State

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1. Trustee also raises the issue of whether the trial court erred in finding that no further hearing or evidence would be necessary to determine the amount to be paid to DMA and, another claimant, United Health Care. Addressing those issues, however, is dependent upon this Court finding in favor of trustee on issue one.

2. Some of the challenged conclusions by the trial court are labeled as "findings of fact" but are actually legal conclusions. Accordingly, we treat them as conclusions of law. *See Zimmerman v. Appalachian State Univ.*, 149 N.C.App. 121, 131, 560 S.E.2d 374, 380 (2002) (conclusions of law are reviewed *de novo* regardless of how they are labeled).

of the right to third party benefits[.]" In other words, the state and county providing the medical benefits are "subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance[.]" N.C. Gen.Stat. § 108A-57(a). The state is entitled to receive funds from third party benefits up to the amount of the Medicaid payments so long as the payment does not exceed "one-third of the gross amount obtained[.]" N.C. Gen.Stat. § 108A-57(a). Trustee argues that the DMA is only entitled to the settlement funds that Katelyn received as compensation for medical expenses and not, for example, any settlement funds paid by the third parties due to her pain and suffering. We disagree.

Our Supreme Court definitively addressed this issue in *Ezell*, which is binding on this Court. *Mahoney v. Ronnie's Road Service*, 122 N.C.App. 150, 153, 468 S.E.2d 279, 281 (1996) ("it is elementary that we are bound by the rulings of our Supreme Court").

Judge Steelman's dissent in *Ezell* was adopted *per curiam* by our Supreme Court. *Ezell*, 360 N.C. 529, 631 S.E.2d 131. In that case, Judge Steelman stated that "[o]ur cases have consistently rejected attempts by plaintiffs to characterize portions of settlements as being for medical bills or for pain and suffering in order to circumvent DMA's statutory lien." *Ezell v. Grace Hosp., Inc.*, 175 N.C.App. 56, 65, 623 S.E.2d 79, 85 (2005) (Steelman, J., dissenting), *dissent adopted per curiam*, 360 N.C. 529, 631 S.E.2d 131. Moreover, the "DMA's right of subrogation under N.C. Gen.Stat. § 108A-57(a) is broad rather than narrow." *Id.* at 66, 623 S.E.2d at

85. In the *Ezell* dissent, which was adopted by the Supreme Court, Judge Steelman concluded that the DMA was subrogated to the entire amount of the settlement, subject only to the one-third limitation found in N.C. Gen.Stat. § 108A-57(a), irrespective of whether some of the settlement amount was intended to account for pain and suffering and not medical damages. *Id.* Such being the case here, it is immaterial that some of plaintiffs' settlement funds might have been attributed to something other than medical damages. Accordingly, the trial court did not err in subrogating the settlements, subject to the one-third statutory limitation, if applicable, to the DMA.

Trustee asks this Court to apply a recent United States Supreme Court decision to interpret our state statutes. In that case, the United States Supreme Court determined that a state's ability to recover its Medicaid lien was limited to that pro-rata portion of the settlement representing compensation for past medical expenses only, not the entire settlement. *Ahlborn,* 547 U.S. at __, 126 S.Ct. 1752, 164 L.Ed.2d at 474. The Court, however, was interpreting an Arkansas statute, not a North Carolina statute. The North Carolina Supreme Court opinion in *Ezell* was handed down on 30 June 2006, which was after the United States Supreme Court's opinion in *Ahlborn,* decided on 1 May 2006. Thereafter, a petition for rehearing was filed with our Supreme Court in *Ezell* on 4 August 2006. Our Supreme Court denied the petition, which set out arguments based on *Ahlborn,* on 14 December 2006. *Ezell,* 361 N.C. 180, 641 S.E.2d 4 (2006) (unpublished). Although we

recognize that the Arkansas statute discussed in *Ahlborn* is similar to the one at issue here, it is well settled that " 'the construction of the statutes of a state by its highest courts is to be regarded as determining their meaning[.]' " *Champion Fibre Co. v. Cozad,* 183 N.C. 600, 607, 112 S.E. 810, 813 (1922) (quoting *Board of Sup'rs of Carroll Co. v. U.S.,* 18 Wall. 71, 85 U.S. 71, 21 L.Ed. 771 (1873)). "Moreover, this Court has no authority to overrule decisions of our Supreme Court and we have the responsibility to follow those decisions 'until otherwise ordered by . . . [our] Supreme Court.' " *Dunn v. Pate,* 106 N.C.App. 56, 60, 415 S.E.2d 102, 104 (1992) (citation omitted), *reversed on other grounds,* 334 N.C. 115, 431 S.E.2d 178 (1993). That not being present here, trustee's arguments as to this issue are rejected.[3]

II.

Trustee next argues that the trial court erred in characterizing the DMA's interest in the settlement account as a "lien" as opposed to a "claim." We disagree.

Several of this Court's decisions have referred to the state's and/or county's interest under N.C. Gen Stat.

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3. Also rejected is trustee's argument that the trial court erred in denying his motion for further hearing as the trial court was under no obligation to make an accounting of those funds in the settlement account attributable to medical expenses. For the same reason, we also reject trustee's arguments that the trial court erred by not addressing any potential claims that United Healthcare could have against the settlement account.

§ 108A-57 in a settlement or judgment as a "lien." *See Campbell v. N.C. Dep't of Human Res.*, 153 N.C.App. 305, 569 S.E.2d 670 (2002); *Payne v. N.C. Dept. of Human Resources*, 126 N.C.App. 672, 486 S.E.2d 469 (1997); *N.C. Dept. of Human Resources v. Weaver*, 121 N.C.App. 517, 466 S.E.2d 717 (1996). Moreover, the statute itself uses the phrase "medical lien" as an alternative way of describing third parties' "medical subrogation rights[.]" N.C. Gen.Stat. § 108A-57(a). Accordingly, trustee's assignments of error as to this issue are rejected.

III.

Trustee next argues that the trial court erred in determining that the DMA is a "beneficiary" of the settlement account as opposed to a "claimant." We agree that the trial court improperly characterized the DMA as a beneficiary but do not find the error to warrant a remand.

"A beneficiary is 'a person who receives benefits[;]' while the definition of benefit includes 'payment made under insurance, social security, welfare, etc.' " *Campbell*, 153 N.C.App. at 307, 569 S.E.2d at 672 (quoting Oxford Encyclopedic English Dictionary 132 (Judy Pearsall and Bill Trumble, eds., 1995)). Accordingly, the "beneficiary" under N.C. Gen.Stat. § 108A-57(a) is the person receiving the Medicaid benefits, be it actual funds or the medical services that have been paid by DMA on behalf of the recipient. *Id.* In the instant case, the DMA was paying plaintiffs, the

beneficiaries. Thus the DMA is not the beneficiary, but a claimant.

It is well settled, however, that "verdicts and judgments will not be set aside for harmless error, or for mere error and no more." *In re Ross' Will,* 182 N.C. 477, 478, 109 S.E. 365, 365 (1921). Instead, trustee must show "not only that the ruling complained of was erroneous, but that it was material and prejudicial, amounting to a denial of some substantial right." *Id.* The rationale being that "appellate courts will not encourage litigation by reversing judgments for slight error, or for stated objections, which could not have prejudiced the rights of appellant in any material way." *Id.* Trustee has failed to establish how such a technical error would require a remand. Accordingly, trustee's arguments as to this issue are rejected.

IV.

In summary, we hold that the trial court did not err in subrogating the settlements, subject to the one-third statutory limitation, if applicable, to the DMA. We also hold that the trial court did not err in characterizing the DMA's claim on the settlement account as a "lien." Finally, we conclude that a remand would not be appropriate in this case even though the trial court incorrectly labeled the DMA as a "beneficiary" of the settlement accounts.

Affirmed.

Judge JACKSON concurs.

Judge WYNN dissents in a separate opinion.

WYNN, Judge, dissenting.

Because I find that our Supreme Court has not yet squarely answered the question presented to us by this case, I certify by dissent for a decision on the issue of whether the amount of the State Division of Medical Assistance's subrogation claim on a Medicaid recipient's settlement is controlled by the United States Supreme Court decision in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006).

Preliminarily, I observe that our state Supreme Court's reversal of this Court's decision in *Ezell v. Grace Hospital, Inc.* was explained only as "[f]or the reasons stated in the dissenting opinion."[4] At the time of this Court's dissenting opinion, the *Ahlborn* decision had not yet been handed down by the United States Supreme Court. As such, the dissenting opinion adopted by our Supreme Court neither considered nor mentioned *Ahlborn*. Moreover, immediately after the issuance of the *Ahlborn* decision, our Supreme Court declined to grant a rehearing in *Ezell* with the one-word reply, "Denied." In denying the plaintiff's petition for

4. *Ezell v. Grace Hospital, Inc.*, 175 N.C.App. 56, 623 S.E.2d 79 (2005), *rev'd per curiam*, 360 N.C. 529, 631 S.E.2d 131, *reh'g denied*, 361 N.C. 180, 641 S.E.2d 4 (2006).

rehearing, the *Ahlborn* decision was again neither addressed nor mentioned. Thus, *Ezell* offers no guidance for determining the inapplicability of the *Ahlborn* holding to this case, and I cannot discern a basis for why the United States Supreme Court decision should not control the outcome.

Accordingly, because the North Carolina statute at issue in this case is materially indistinguishable from the Arkansas statutory provisions found by a unanimous United States Supreme Court in *Ahlborn* to be preempted by federal law, I respectfully dissent.

The relevant North Carolina statutes provide that, by accepting medical assistance from the State, "the recipient shall be deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which he may be entitled." N.C. Gen.Stat. § 108A-59(a) (2005). In turn, "to the extent of payments under [the Medical Assistance Program], the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance . . . against any person [,]" although "the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered." *Id.* § 108A-57(a).

Likewise, the Arkansas statute at issue in the *Ahlborn* case gave that state the "right to recover from the person the cost of benefits so provided[,]" when medical assistance benefits were provided "because of

injury, disease, or disability for which another person is liable[.]" Ark.Code Ann. § 20-77-301(a) (2005). Further, "any settlement, judgment, or award obtained [by the individual] is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program." *Id.* § 20-77-302(a). After paying attorney's fees and expenses, the Arkansas Department of Human Services (ADHS) would "receive an amount sufficient to reimburse the department the full amount of benefits paid on behalf of the recipient under the medical assistance program[,]" with "[t]he remainder [to] be awarded to the medical assistance recipient." *Id.* § 20-77-302(b). The assignment was considered a condition of Medicaid benefits and an automatic statutory lien on any settlement with a third party. *Id.* § 20-77-307.

The principal difference between the North Carolina and Arkansas statutes is that the latter provides no ceiling or limit on the amount of recovery allowed to the ADHS; rather, the statute explicitly stated that ADHS was entitled to recover the full amount of the benefits paid to the recipient. *Id.* § 20-77-302(b). North Carolina, by contrast, allows DMA to take at most one-third of the gross amount of the settlement, regardless of whether that fully satisfies the amount paid in medical benefits. N.C. Gen.Stat. § 108A-57(a). Nevertheless, the basic thrust of the statutes is the same: under both, the State has an automatic lien on the full amount of any settlement with a third party reached by a Medicaid settlement, regardless of what expenses or damages those funds are designated to compensate.

Appendix B

In *Ahlborn*, the United States Supreme Court focused on that specific issue, stating, "We must decide whether ADHS can lay claim to more than the portion of [the recipient's] settlement that represents medical expenses." 547 U.S. at 280, 126 S.Ct. at 1760, 164 L.Ed.2d at 471. The holding of the Court was that ADHS could not:

> The text of the federal third-party liability provisions suggests not; it focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party," 42 U.S.C. § 1396k(a)(1)(A) (emphasis added), not rights to payment for, for example, lost wages.

Id., 126 S.Ct . at 1760-61. Even more explicitly:

> [A]s explained above, under the federal statute the State's assigned rights extend only to recovery of payments for medical care. Accordingly, what § 1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care.

Id. at 281, 126 S.Ct. at 1761, 164 L.Ed.2d at 472.

Moreover, the United States Supreme Court found that the Arkansas statute conflicted with the federal statute's "express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf[,]" namely, the anti-lien provisions of 42 U.S.C. §§ 1396a(a)(18) and 1396p. *Id.* at 283, 126 S.Ct. at 1762, 164 L.Ed.2d at 473. According to the Supreme Court:

> There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§ 1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. . . . But that does not mean that the State can force an assignment of, or place a lien on, any other portion of [the recipient's] property. *As explained above, the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.*

Id. at 284-85, 126 S.Ct. at 1763, 164 L.Ed.2d at 474 (citation omitted and emphasis added). Thus, the Arkansas statute-and likewise, our North Carolina

statute-conflicts with federal Medicaid statutes by allowing the State to recover from a recipient settlement funds that were for purposes other than medical expenses.

In the instant case, Katelyn and her parents brought suit against the hospital, doctors, and nurses charged with her birth for damages including, but not limited to, mental and physical pain and anguish, severe and permanent injury, past medical expenses paid by Medicaid, her insurance company, and her parents, future medical expenses, loss of future earnings, disfigurement and loss of normal use of her body, her parents' expenses for education and life care, and her parents' emotional distress and derivative claims. These claims were settled among all parties, with proceeds held in a single account and no allocations made as to specific amounts for which particular claim. Although the settlement is in excess of three times the amount of medical expenses paid by DMA, such that DMA could receive full reimbursement without violating the provisions of N.C. Gen.Stat. § 108A-57(a), the holding of *Ahlborn* dictates that the trial court must hold an evidentiary hearing as to what portion of the settlement is designated for medical expenses prior to determination of the amount of repayment to be made to DMA.

Accordingly, I respectfully dissent.

APPENDIX C — EXCERPTS FROM THE ORDER ENTERED BY THE SUPERIOR COURT FOR ALAMANCE COUNTY NORTH CAROLINA IN MATTER NO. 04CVS286 SIGNED JULY 10, 2006 AND FILED JULY 27, 2006 (FILED UNDER SEAL)

Although the Order was submitted under seal, the following are relevant excerpts from that Order:

Finding of Fact No. 4 provided in part as follows:

"DMA is a beneficiary of the Katelyn Andrews Segregated Settlement Account"

DMA is subrogated under N.C.Gen.Stat. §108A-57 of settlement funds received by the Plaintiff.

Finding of Fact No. 5: "Pursuant to G.S. 108A-57 DMA is subrogated to Katelyn Andrews' rights to recovery from medical expenses paid."

Finding of Fact No. 7: "No further hearing or evidence is required in this matter in order for the Court to determine the amount to paid from the Katelyn Andrews Segregated Settlement Account in satisfaction of DMA's lien."

Finding of Fact No. 13: "That DMA has a valid lien in the amount of $1,046,681.94 on the settlement funds."

Conclusion of Law No.2: That "No further hearing or evidence is required in this matter in order for the Court to determine the amount to be paid from the Katelyn Andrews Segregated Settlement Account in satisfaction of DMA's lien."

Appendix C

Conclusion of Law No. 4: That "Pursuant to N.C.Gen.Stat. §108A-59 and §108A-57 and pursuant to *Ezell v. Grace Hospital,* DMA is subrogated to the minor child Katelyn Andrews' right of recovery in the instant action for medical expenses."

Conclusion of Law No. 6: That "Pursuant to GS §108A-57, DMA's lien for $1,046,681.94 must be paid in full."

Conclusion of Law No. 7: That "The trustee's request for the court to consider and take evidence relating to the reasonable value of the case in relation to the amount of past medical expenses, or to otherwise allocate the settlement amounts under Arkansas v. Ahlborn . . . should be denied because of the North Carolina Supreme Court's decision in Ezell v. Grace Hospital . . . is controlling."

The Court's Order and Decree No. 2: That "The Trustee's request for an evidentiary hearing on the reasonable value of the case relative to DMA expenses is denied."

The Court's Order and Decree No. 4: That "The Trustee of the Katelyn Andrews Segregated Settlement Account is ordered to pay the North Carolina Department of Health and Human Services, Division of Medical Assistance, the sum of $1,046,681.94."

APPENDIX D — ARKANSAS DEPARTMENT OF HUMAN SERVICES, ET AL. v. AHLBORN OF THE SUPREME COURT OF THE UNITED STATES DECIDED MAY 1, 2006

SUPREME COURT OF THE UNITED STATES

No. 04-1506.

Argued Feb. 27, 2006.

Decided May 1, 2006.

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Petitioners,

v.

Heidi AHLBORN.

*Syllabus**

Federal Medicaid law requires participating States to "ascertain the legal liability of third parties . . . to pay for [an individual benefits recipient's] care and services available under the [State's] plan," 42 U.S.C. § 1396a(a)(25)(A); to "seek reimbursement for [medical] assistance to the extent of such legal liability,"

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* The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U.S. 321, 337, 26 S.Ct. 282, 50 L.Ed. 499.

§1396a(a)(25)(B); to enact "laws under which, to the extent that payment has been made . . . for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services," § 1396a(a)(25)(H); to "provide that, as a condition of [Medicaid] eligibility . . . , the individual is required . . . (A) to assign the State any rights . . . to payment for medical care from any third party; . . . (B) to cooperate with the State . . . in obtaining [such] payments . . . and . . . (C) . . . in identifying, and providing information to assist the State in pursuing, any third party who may be liable," §1396k(a)(1). Finally, "any amount collected by the State under an assignment made" as described above "shall be retained by the State . . . to reimburse it for [Medicaid] payments made on behalf of" the recipient. § 1396k(b). "[T]he remainder of such amount collected shall be paid" to the recipient. *Ibid.* Acting pursuant to its understanding of these provisions, Arkansas passed laws under which, when a state Medicaid recipient obtains a tort settlement following payment of medical costs on her behalf, a lien is automatically imposed on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement representing medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs, such as pain and suffering, lost wages, and loss of future earnings.

Appendix D

Following respondent Ahlborn's car accident with allegedly negligent third parties, petitioner Arkansas Department of Health and Human Services, then named Arkansas Department of Human Services (ADHS), determined that Ahlborn was eligible for Medicaid and paid providers $215,645.30 on her behalf. She filed a state-court suit against the alleged tortfeasors seeking damages for past medical costs and for other items including pain and suffering, loss of earnings and working time, and permanent impairment of her future earning ability. The case was settled out of court for $550,000, which was not allocated between categories of damages. ADHS did not participate or ask to participate in the settlement negotiations, and did not seek to reopen the judgment after the case was dismissed, but did intervene in the suit and assert a lien against the settlement proceeds for the full amount it had paid for Ahlborn's care. She filed this action in Federal District Court seeking a declaration that the State's lien violated federal law insofar as its satisfaction would require depletion of compensation for her injuries other than past medical expenses. The parties stipulated, *inter alia*, that the settlement amounted to approximately one-sixth of the reasonable value of Ahlborn's claim and that, if her construction of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made. In granting ADHS summary judgment, the court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned ADHS her right to recover the full amount of Medicaid's payments for her

benefit. The Eighth Circuit reversed, holding that ADHS was entitled only to that portion of the settlement that represented payments for medical care.

Held: Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion. Pp. 1760-1767.

(a) Arkansas' statute finds no support in the federal third-party liability provisions. That ADHS cannot claim more than the portion of Ahlborn's settlement that represents medical expenses is suggested by § 1396k(a)(1)(A), which requires that Medicaid recipients, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party" (emphasis added), not their rights to payment for, *e.g.*, lost wages. The other statutory language ADHS relies on is not to the contrary, but reinforces the assignment provision's implicit limitation. First, statutory context shows that § 1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance *to the extent of such legal liability*" refers to "the legal liability of third parties . . . *to pay for care and services available under the plan*," § 1396a(a)(25)(A) (emphases added). Here, because the tortfeasors accepted liability for only one-sixth of Ahlborn's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents

compensation for medical expenses, the relevant "liability" extends no further than that amount. Second, § 1396a(a)(25)(H)'s requirement that the State enact laws giving it the right to recover from liable third parties "to the extent [it made] payment . . . for medical assistance for health care items or services furnished to an individual" does not limit the State's recovery only by the amount it paid out on the recipient's behalf, since the rest of the provision makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services.*" (Emphasis added.) Finally, § 1396k(b)'s requirement that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient does not show that the State must be paid in full from any settlement. Rather, because the State's assigned rights extend only to recovery of medical payments, what § 1396k(b) requires is that the State be paid first out of any damages for medical care before the recipient can recover any of her own medical costs. Pp. 1760-1762.

(b) Arkansas' statute squarely conflicts with the federal Medicaid law's anti-lien provision, § 1396p(a)(1), which prohibits States from imposing liens "against the property of any individual prior to his death on account of medical assistance paid . . . on his behalf under the State plan." Even if the State's lien is assumed to be consistent with federal law insofar as it encumbers proceeds designated as medical payments, the anti-lien

provision precludes attachment or encumbrance of the remainder of the settlement. ADHS' attempt to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property," but as the State's, fails for two reasons. First, because the settlement is not "received from a third party," as required by the state statute, until Ahlborn's chose in action has been reduced to proceeds in her possession, the assertion that any of the proceeds belonged to the State all along lacks merit. Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory lien on those proceeds: ADHS would not need a lien on its own property. Pp. 1762-1764.

(c) The Court rejects as unpersuasive ADHS' and the United States' arguments that a rule permitting a lien on more than medical damages ought to apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. As § 1396k(a)(1)(C) demonstrates, the duty to cooperate arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties. In any event, the aspersions cast upon Ahlborn are entirely unsupported; all the record reveals is that ADHS neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here. Although more colorable, the alternative argument that a rule of full reimbursement is needed

generally to avoid the risk of settlement manipulation also fails. The risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision. Pp. 1764-1765.

(d) Also rejected is ADHS' contention that the Eighth Circuit accorded insufficient weight to two decisions by the Departmental Appeals Board (Board) of the federal Department of Health and Human Services (HHS) rejecting appeals by two States from denial of reimbursement for costs they paid on behalf of Medicaid recipients who had settled tort claims. Although HHS generally has broad regulatory authority in the Medicaid area, the Court declines to treat the Board's reasoning in those cases as controlling because they address a different question from the one posed here, make no mention of the anti-lien provision, and rest on a questionable construction of the federal third-party liability provisions. Pp. 1765-1767.

397 F.3d 620, affirmed.

Appendix D

STEVENS, J., delivered the opinion for a unanimous Court.

Justice STEVENS delivered the opinion of the Court.

When a Medicaid recipient in Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs-like pain and suffering, lost wages, and loss of future earnings. The Court of Appeals for the Eighth Circuit held that this statutory lien contravened federal law and was therefore unenforceable. *Ahlborn v. Arkansas Dept. of Human Servs.*, 397 F.3d 620 (2005). Other courts have upheld similar lien provisions. See, *e.g.*, *Houghton v. Dept. of Health*, 2002 UT 101, 57 P.3d 1067; *Wilson v. Washington*, 142 Wash.2d 40, 10 P.3d 1061 (2000) (en banc). We granted certiorari to resolve the conflict, 545 U.S. 1165, 126 S.Ct. 35, 162 L.Ed.2d 933 (2005), and now affirm.

I

On January 2, 1996, respondent Heidi Ahlborn, then a 19-year-old college student and aspiring teacher, suffered severe and permanent injuries as a result of a car accident. She was left brain damaged, unable to

complete her college education, and incapable of pursuing her chosen career. Although she possessed a claim of uncertain value against the alleged tortfeasors who caused her injuries, Ahlborn's liquid assets were insufficient to pay for her medical care. Petitioner Arkansas Department of Health and Human Services (ADHS)[1] accordingly determined that she was eligible for medical assistance and paid providers $215,645.30 on her behalf under the State's Medicaid plan.

ADHS required Ahlborn to complete a questionnaire about her accident, and sent her attorney periodic letters advising him about Medicaid outlays. These letters noted that, under Arkansas law, ADHS had a claim to reimbursement from "any settlement, judgment, or award" obtained by Ahlborn from "a third party who may be liable for" her injuries, and that no settlement "shall be satisfied without first giving [ADHS] notice and a reasonable opportunity to establish its interest."[2] ADHS has never asserted, however, that Ahlborn has a duty to reimburse it out of any other subsequently acquired assets or earnings.

On April 11, 1997, Ahlborn filed suit against two alleged tortfeasors in Arkansas state court seeking compensation for the injuries she sustained in the January 1996 car accident. She claimed damages not

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1. ADHS was then named Arkansas Department of Human Services.

2. Affidavit of Wayne E. Olive, Exhs. 5 and 6 (Mar. 6, 2003).

only for past medical costs, but also for permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future.

ADHS was neither named as a party nor formally notified of the suit. Ahlborn's counsel did, however, keep ADHS informed of details concerning insurance coverage as they became known during the litigation.

In February 1998, ADHS intervened in Ahlborn's lawsuit to assert a lien on the proceeds of any third-party recovery Ahlborn might obtain. In October 1998, ADHS asked Ahlborn's counsel to notify the agency if there was a hearing in the case. No hearing apparently occurred, and the case was settled out of court sometime in 2002 for a total of $550,000. The parties did not allocate the settlement between categories of damages. ADHS did not participate or ask to participate in settlement negotiations. Nor did it seek to reopen the judgment after the case had been dismissed. ADHS did, however, assert a lien against the settlement proceeds in the amount of $215,645.30–the total cost of payments made by ADHS for Ahlborn's care.

On September 30, 2002, Ahlborn filed this action in the United States District Court for the Eastern District of Arkansas seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses. To facilitate the District

Court's resolution of the legal questions presented, the parties stipulated that Ahlborn's entire claim was reasonably valued at $3,040,708.12; that the settlement amounted to approximately one-sixth of that sum; and that, if Ahlborn's construction of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made. See App. 17-20.

Ruling on cross-motions for summary judgment, the District Court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned to ADHS her right to any recovery from the third-party tortfeasors to the full extent of Medicaid's payments for her benefit. Accordingly, ADHS was entitled to a lien in the amount of $215,645.30.

The Eighth Circuit reversed. It held that ADHS was entitled only to that portion of the judgment that represented payments for medical care. For the reasons that follow, we affirm.

II

The crux of the parties' dispute lies in their competing constructions of the federal Medicaid laws. The Medicaid program, which provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs, was launched in 1965 with the enactment of Title XIX of the Social Security Act (SSA), as added, 79 Stat. 343, 42 U.S.C. § 1396 *et seq.* (2000 ed. and Supp. III). Its administration

is entrusted to the Secretary of Health and Human Services (HHS), who in turn exercises his authority through the Centers for Medicare and Medicaid Services (CMS).[3]

States are not required to participate in Medicaid, but all of them do. The program is a cooperative one; the Federal Government pays between 50% and 83% of the costs the State incurs for patient care,[4] and, in return, the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program. See § 1396a.

One such requirement is that the state agency in charge of Medicaid (here, ADHS) "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan." § 1396a(a)(25)(A) (2000 ed.).[5] The agency's obligation extends beyond mere identification, however;

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3. Until 2001, CMS was known as the Health Care Financing Administration or HCFA. See 66 Fed.Reg. 35437.

4. The exact percentage of the federal contribution is calculated pursuant to a formula keyed to each State's per capita income. See 42 U.S.C. § 1396d(b).

5. A "third party" is defined by regulation as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan." 42 CFR § 433.136 (2005).

> "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability." § 1396a(a)(25)(B).

To facilitate its reimbursement from liable third parties, the State must,

> "to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, [have] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services." § 1396a(a)(25)(H).

The obligation to enact assignment laws is reiterated in another provision of the SSA, which reads as follows:

> "(a) For the purpose of assisting in the collection of medical support payments and

other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall–

"(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required–

"(A) to assign the State any rights . . . to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

"(B) to cooperate with the State . . . in obtaining support and payments (described in subparagraph (A)) for himself . . . ; and

"(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan . . . ." § 1396k(a).

Finally, "any amount collected by the State under an assignment made" as described above "shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of" the

> Medicaid recipient. § 1396k(b). "[T]he remainder of such amount collected shall be paid" to the recipient. *Ibid.*

Acting pursuant to its understanding of these third-party liability provisions, the State of Arkansas passed laws that purport to allow both ADHS and the Medicaid recipient, either independently or together, to recover "the cost of benefits" from third parties. Ark.Code Ann. §§ 20-77-301 through 20-77-309 (2001). Initially, "[a]s a condition of eligibility" for Medicaid, an applicant "shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." § 20-77-307(a). Accordingly, "[w]hen medical assistance benefits are provided" to the recipient "because of injury, disease, or disability for which another person is liable," ADHS "shall have a right to recover from the person the cost of benefits so provided." § 20-77-301(a).[6] ADHS' suit "shall" not, however, "be a bar to any action upon the claim or cause of action of the recipient." § 20-77-301(b). Indeed, the statute envisions that the recipient will sometimes sue together with ADHS, see § 20-77-303, or even alone.

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6. Under the Arkansas statute, ADHS' right to recover medical costs appears to be broader than that of the recipient. When ADHS sues, "no contributory or comparative fault of a recipient shall be attributed to the state, nor shall any restitution awarded to the state be denied or reduced by any amount or percentage of fault attributed to a recipient." § 20-77-301(d)(1) (2001).

If the latter, the assignment described in § 20-77-307(a) "shall be considered a statutory lien on any settlement, judgment, or award received . . . from a third party." § 20-77-307(c); see also § 20-77-302(a) ("When an action or claim is brought by a medical assistance recipient . . . , any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program").[7]

The State, through this statute, claims an entitlement to more than just that portion of a judgment or settlement that represents payment for medical expenses. It claims a right to recover the entirety of the costs it paid on the Medicaid recipient's behalf. Accordingly, if, for example, a recipient sues alone and settles her entire action against a third-party tortfeasor for $20,000, and ADHS has paid that amount or more to medical providers on her behalf, ADHS gets the whole settlement and the recipient is left with nothing. This is so even when the parties to the settlement allocate damages between medical costs, on the one hand, and other injuries like lost wages, on the other. The same rule also would apply, it seems, if the recovery were the result not of a settlement but of a jury verdict. In that case, under the Arkansas statute, ADHS could recover

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7. The Arkansas Supreme Court has held that ADHS has an independent, nonderivative right to recover the cost of benefits from a third-party tortfeasor under § 20-77-301 even when the Medicaid recipient also sues for recovery of medical expenses. See *National Bank of Commerce v. Quirk*, 323 Ark. 769, 792-794, 918 S.W.2d 138, 151-152 (1996).

the full $20,000 in the face of a jury allocation of, say, only $10,000 for medical expenses.[8]

That this is what the Arkansas statute requires has been confirmed by the State's Supreme Court. In *Arkansas Dept. of Human Servs. v. Ferrel,* 336 Ark. 297, 984 S.W.2d 807 (1999), the court refused to endorse an equitable, nontextual interpretation of the statute. Rejecting a Medicaid recipient's argument that he ought to retain some of a settlement that was insufficient to cover both his and Medicaid's expenses, the court explained:

> "Given the clear, unambiguous language of the statute, it is apparent that the legislature intended that ADHS's ability to recoup Medicaid payments from third parties or recipients not be restricted by equitable subrogation principles such as the 'made whole' rule stated in [*Franklin v. Healthsource of Arkansas,* 328 Ark. 163, 942 S.W.2d 837 (1997)]. By creating an automatic legal assignment which expressly becomes a statutory lien, [Ark.Code Ann. § 20-77-307 (1991)] makes an unequivocal statement that the ADHS's ability to recover Medicaid payments from insurance settlements, if it so

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8. ADHS denies that it would actually demand the full $20,000 in such a case, see Brief for Petitioners 49, n. 13, but points to no provision of the Arkansas statute that would prevent it from doing so.

> chooses, is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs." *Id.*, at 308, 984 S.W.2d, at 811.

Accordingly, the Arkansas statute, if enforceable against Ahlborn, authorizes imposition of a lien on her settlement proceeds in the amount of $215,645.30. Ahlborn's argument before the District Court, the Eighth Circuit, and this Court has been that Arkansas law goes too far. We agree. Arkansas' statute finds no support in the federal third-party liability provisions, and in fact squarely conflicts with the anti-lien provision of the federal Medicaid laws.

III

We must decide whether ADHS can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses.[9] The text of the federal third-party liability provisions suggests not; it focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party," 42 U.S.C. § 1396k(a)(1)(A) (emphasis

9. The parties here assume, as do we, that a State can fulfill its obligations under the federal third-party liability provisions by requiring an "assignment" of part of, or placing a lien on, the settlement that a Medicaid recipient procures on her own. Cf. §§ 1396k(a)(1)(B)-(C) (the recipient has a duty to identify liable third parties and to "provid[e] information to *assist the State in pursuing*" those parties (emphasis added)).

added), not rights to payment for, for example, lost wages. The other statutory language that ADHS relies upon is not to the contrary; indeed, it reinforces the limitation implicit in the assignment provision.

First, ADHS points to § 1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance *to the extent of such legal liability* " (emphasis added) and suggests that this means that the entirety of a recipient's settlement is fair game. In fact, as is evident from the context of the emphasized language, "such legal liability" refers to "the legal liability of third parties . . . *to pay for care and services available under the plan.*" § 1396a(a)(25)(A) (emphasis added). Here, the tortfeasor has accepted liability for only one-sixth of the recipient's overall damages, and ADHS has stipulated that only $35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, the relevant " liability" extends no further than that amount.[10]

Second, ADHS argues that the language of § 1396a(a)(25)(H) favors its view that it can demand full reimbursement of its costs from Ahlborn's settlement. That provision, which echoes the requirement of a mandatory assignment of rights in § 1396k(a), says that the State must have in effect laws that, "to the extent

10. The effect of the stipulation is the same as if a trial judge had found that Ahlborn's damages amounted to $3,040,708.12 (of which $215,645.30 were for medical expenses), but because of her contributory negligence, she could only recover one-sixth of those damages.

that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual," give the State the right to recover from liable third parties. This must mean, says ADHS, that the agency's recovery is limited only by the amount it paid out on the recipient's behalf-and not by the third-party tortfeasor's particular liability for medical expenses. But that reading ignores the rest of the provision, which makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services*." § 1396a(a)(25)(H) (emphasis added). Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses–not lost wages, not pain and suffering, not an inheritance.

Finally, ADHS points to the provision requiring that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient. § 1396k(b). In ADHS' view, this shows that the State must be paid in full from any settlement. See Brief for Petitioners 13. But, even assuming the provision applies in cases where the State does not actively participate in the litigation, ADHS' conclusion rests on a false premise: The "amount recovered . . . under an assignment" is not, as ADHS assumes, the entire settlement; as explained above, under the federal statute the State's assigned rights extend only to recovery of payments for medical care. Accordingly, what § 1396k(b) requires is that the State

be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care.[11]

At the very least, then, the federal third-party liability provisions *require* an assignment of no more than the right to recover that portion of a settlement

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11. Implicit in ADHS' interpretation of this provision is the assumption that there can be no "remainder" to remit to the Medicaid recipient if all the State has been assigned is the right to damages for medical expenses. That view in turn seems to rest on an assumption either that Medicaid will have paid all the recipient's medical expenses or that Medicaid's expenses will always exceed the portion of any third-party recovery earmarked for medical expenses. Neither assumption holds up. First, as both the Solicitor General and CMS acknowledge, the recipient often will have paid medical expenses out of her own pocket. See Brief for United States as *Amicus Curiae* 12 (under § 1396k(b), "the beneficiary retains the right to payment for any additional medical expenses personally incurred either before or subsequent to Medicaid eligibility and for other damages"); CMS, State Medicaid Manual § 3907, available at https:// www.lexis.com>Legal>Secondary Legal>CCH> Health Law>CMS Program Manuals>CCH CMS Program Manuals P 3907 (as updated Mar. 25, 2006, and available in Clerk of Court's case file) (envisioning that "medical insurance payments," for example, will be remitted to the recipient if possible). Second, even if Medicaid's outlays often exceed the portion of the recovery earmarked for medical expenses in tort cases, the third-party liability provisions were not drafted exclusively with tort settlements in mind. In the case of health insurance, for example, the funds available under the policy may be enough to cover both Medicaid's costs and the recipient's own medical expenses.

that represents payments for medical care.[12] They did not mandate the enactment of the Arkansas scheme that we have described.

IV

If there were no other relevant provisions in the federal statute, the State might plausibly argue that federal law supplied a recovery "floor" upon which States were free to build. In fact, though, the federal statute places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf. These limitations are contained in 42 U.S.C. §§ 1396a(a)(18) and 1396p. Section 1396a(a)(18) requires that a state Medicaid plan comply with § 1396p, which in turn prohibits States (except in circumstances not relevant here) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient:

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12. ADHS concedes that, had a jury or judge allocated a sum for medical payments out of a larger award in this case, the agency would be entitled to reimburse itself only from the portion so allocated. See Brief for Petitioners 49, n. 13; see also Brief for United States as *Amicus Curiae* 22, n. 14 (noting that the Secretary of HHS "ordinarily accepts" a jury allocation of medical damages in satisfaction of the Medicaid debt, even where smaller than the amount of Medicaid's expenses). Given the stipulation between ADHS and Ahlborn, there is no textual basis for treating the settlement here differently from a judge-allocated settlement or even a jury award; all such awards typically establish a third party's "liability" for both "payment for medical care" and other heads of damages.

"(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

"(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except–

"(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

"(B) [in certain circumstances not relevant here]

* * *

"(b) Adjustment or recovery of medical assistance correctly paid under a State plan

"(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except [in circumstances not relevant here]." § 1396p.

Read literally and in isolation, the anti-lien prohibition contained in § 1396p(a) would appear to ban even a lien on that portion of the settlement proceeds

that represents payments for medical care.[13] Ahlborn does not ask us to go so far, though; she assumes that the State's lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement.

We agree. There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§ 1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. See *Washington State Dept. of Social and Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 383-385, and n. 7, 123 S.Ct. 1017, 154 L.Ed.2d 972 (2003).

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13. Likewise, subsection (b) would appear to forestall any attempt by the State to recover benefits paid, at least from the "individual." See, *e.g.*, *Martin ex rel. Hoff v. Rochester*, 642 N.W.2d 1, 8, n. 6 (Minn.2002); *Wallace v. Estate of Jackson*, 972 P.2d 446, 450 (Utah 1998) (Durham, J., dissenting) (reading § 1396p to "prohibi[t] not only liens against Medicaid recipients but also any recovery for medical assistance correctly paid"). The parties here, however, neither cite nor discuss the antirecovery provision of § 1396p(b). Accordingly, we leave for another day the question of its impact on the analysis.

But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.

ADHS tries to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property."[14] Its argument appears to be that the automatic assignment effected by the Arkansas statute rendered the proceeds the property of the State.[15] See Brief for Petitioners 31 ("[U]nder Arkansas law, the lien does not attach to the recipient's 'property' because it attaches only to those proceeds already assigned to the Department as a condition of Medicaid eligibility"). That argument fails for two reasons. First, ADHS insists that Ahlborn at all times until judgment retained her entire chose in action–a right that included her claim

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14. "Property" is defined by regulation as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 CFR § 433.36(b) (2005).

15. The United States as *amicus curiae* makes the different argument that the proceeds never became Ahlborn's "property" because "to the extent the third party's payment passes through the recipient's hands en route to the State, it comes with the State's lien already attached." Brief as *Amicus Curiae* 18. Even if that reading were consistent with the Arkansas statute (and it is not, see *infra*, at 1764), the United States' characterization of the "assignment" simply reinforces Ahlborn's point: This is a lien that attaches *to the property of the recipient.*

for medical damages. The statutory lien, then, cannot have attached until the proceeds materialized. That much is clear from the text of the Arkansas statute, which says that the "assignment shall be considered a statutory lien on any settlement . . . *received by the recipient from a third party.*" Ark.Code Ann. § 20-77-307(c) (2001) (emphasis added). The settlement is not "received" until the chose in action has been reduced to proceeds in Ahlborn's possession. Accordingly, the assertion that any of the proceeds belonged to the State all along lacks merit.

Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory lien on those proceeds. Why, after all, would ADHS need a lien on its own property? A lien typically is imposed on the property of *another* for payment of a debt owed by that other. See Black's Law Dictionary 922 (6th ed.1990). Nothing in the Arkansas statute defines the term otherwise.

That the lien is also called an "assignment" does not alter the analysis. The terms that Arkansas employs to describe the mechanism by which it lays claim to the settlement proceeds do not, by themselves, tell us whether the statute violates the anti-lien provision. See *United States v. Craft,* 535 U.S. 274, 279, 122 S.Ct. 1414, 152 L.Ed.2d 437 (2002); *Drye v. United States,* 528 U.S. 49, 58-61, 120 S.Ct. 474, 145 L.Ed.2d 466 (1999). Although denominated an "assignment," the effect of the statute here was not to divest Ahlborn of all her

property interest; instead, Ahlborn retained the right to sue for medical care payments, and the State asserted a right to the fruits of that suit once they materialized. In effect, and as at least some of the statutory language recognizes, Arkansas has imposed a lien on Ahlborn's property.[16] Since none of the federal third-party liability provisions excepts that lien from operation of the anti-lien provision, its imposition violates federal law.

V

ADHS and its *amici* urge, however, that even if a lien on more than medical damages would violate federal law in some cases, a rule permitting such a lien ought to

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16. Because ADHS insists that "Arkansas law did *not* require Ahlborn to assign her claim or her right to sue," Brief for Petitioners 33 (emphasis in original), we need not reach the question whether a State may force a recipient to assign a chose in action to receive as much of the settlement as is necessary to pay Medicaid's costs. The Eighth Circuit thought this would be impermissible because the State cannot "circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain." App. to Pet. for Cert. 6. Indeed, ADHS acknowledges that Arkansas cannot, for example, require a Medicaid applicant to assign in advance any right she may have to recover an inheritance or an award in a civil case not related to her injuries or medical care. This arguably is no different; as with assignment of those other choses in action, assignment of the right to compensation for lost wages and other nonmedical damages is nowhere authorized by the federal third-party liability provisions.

apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. Neither argument is persuasive.

The United States proposes a default rule of full reimbursement whenever the recipient breaches her duty to "cooperate," and asserts that Ahlborn in fact breached that duty.[17] But, even if the Government's allegations of obstruction were supported by the record, its conception of the duty to cooperate strays far beyond the text of the statute and the relevant regulations. The duty to cooperate arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties. See 42 U.S.C. § 1396k(a)(1)(C) (recipients must "cooperate with the State in identifying . . . and providing information to assist the State in pursuing" third parties). Most of the accompanying federal regulations simply echo this basic duty; all they add is that the recipient must "[p]ay to the agency any support or medical care funds received that are covered by the assignment of rights." 42 CFR § 433.147(b)(4) (2005).

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17. See, *e.g.*, Brief for United States as *Amicus Curiae* 14 (alleging that Ahlborn "omitt[ed] or understat[ed] the medical damages claim from her lawsuit and attempt[ed] to horde for herself the third-party liability payments"); *id.*, at 15 ("[H]aving forsaken her federal and state statutory duties of candid and forthcoming cooperation[,] respondent, rather than the taxpayers, must bear the financial consequences of her actions"); *id.*, at 21, 24 (referring to Ahlborn's "backdoor settlement" and "obstruction and attrition," as well as her "calculated evasion of her legal obligations").

In any event, the aspersions the United States casts upon Ahlborn are entirely unsupported; all the record reveals is that ADHS, despite having intervened in the lawsuit and asked to be apprised of any hearings, neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here.

ADHS' and the United States' alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation is more colorable, but ultimately also unpersuasive. The issue is not, of course, squarely presented here; ADHS has stipulated that only $35,581.47 of Ahlborn's settlement proceeds properly are designated as payments for medical costs. Even in the absence of such a postsettlement agreement, though, the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.[18] For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a

18. As one *amicus* observes, some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers' rights to recovery are at issue. See Brief for Association of Trial Lawyers of America 20-21. Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.

countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others.[19]

VI

Finally, ADHS contends that the Court of Appeals' decision below accords insufficient weight to two decisions by the Departmental Appeals Board of HHS (Board) rejecting appeals by the States of California and Washington from denial of reimbursement for costs those States paid on behalf of Medicaid recipients who had settled tort claims. See App. to Pet. for Cert. 45-67 (reproducing *In re Washington State Dept. of Social & Health Servs.*, Dec. No. 1561, 1996 WL 157123 (HHS Dept.App. Bd., Feb. 7, 1996)); App. to Pet. for Cert. 68-86 (reproducing *In re California Dept. of Health Servs.*, Dec. No. 1504, 1995 WL 66334 (HHS Dept.App. Bd., Jan. 5, 1995)). Because the opinions in those cases address a different question from the one posed here, make no mention of the anti-lien provision, and, in any event, rest

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19. The point is illustrated by state cases involving the recovery of workers' compensation benefits paid to an employee (or the family of an employee) whose injuries were caused by a third-party tortfeasor. In *Flanigan v. Department of Labor and Industries*, 123 Wash.2d 418, 869 P.2d 14 (1994), for example, the court concluded that the state agency could not satisfy its lien out of damages the injured worker's spouse recovered as compensation for loss of consortium. The court explained that the department could not "share in damages for which it has provided no compensation" because such a result would be "absurd and fundamentally unjust." *Id.*, at 426, 869 P.2d, at 17.

on a questionable construction of the federal third-party liability provisions, we conclude that they do not control our analysis.

Normally, if a State recovers from a third party the cost of Medicaid benefits paid on behalf of a recipient, the Federal Government owes the State no reimbursement, and any funds already paid by the Federal Government must be returned. See 42 CFR § 433.140(a)(2) (2005) (federal financial participation "is not available in Medicaid payments if . . . [t]he agency received reimbursement from a liable third party"); § 433.140(c). Washington and California both had adopted schemes according to which the State refrained from claiming full reimbursement from tort settlements and instead took only a portion of each settlement. (In California, the recipient typically could keep at least 50% of her settlement, see App. to Pet. for Cert. 72; in Washington, the proportion varied from case to case, see *id.*, at 48-51.) Each scheme resulted in the State's having to pay a portion of the recipient's medical costs-a portion for which the State sought partial reimbursement from the Federal Government. CMS (then called HCFA) denied this partial reimbursement on the ground that the States had an absolute duty to seek full payment of medical expenses from third-party tortfeasors.

The Board upheld CMS' determinations. In California's appeal, which came first, the Board concluded that the State's duty to seek recovery of benefits "from available third party sources to the fullest

extent possible" included demanding full reimbursement from the entire proceeds of a Medicaid recipient's tort settlement. *Id.*, at 76. The Board acknowledged that § 1396k(a) "refers to assignment only of 'payment for medical care,' " but thought that "the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first." *Ibid.* The Board gave two other reasons for siding with CMS: First, the legislative history of the third-party liability evinced a congressional intent that "the Medicaid program . . . be reimbursed from available third party sources to the fullest extent possible," *ibid.*; and, second, California had long been on notice that it would not be reimbursed for any shortfall resulting from failure to fully recoup Medicaid's costs from tort settlements, see *id.*, at 77. The Board also opined that the State could not escape its duty to seek full reimbursement by relying on the Medicaid recipient's efforts in litigating her claims. See *id.*, at 79-80.

Finally, responding to the State's argument that its scheme gave Medicaid recipients incentives to sue third-party tortfeasors and thus resulted in both greater recovery and lower costs for the State, the Board observed that "a state is free to allow recipients to retain the state's share" of any recovery, so long as it does not compromise the Federal Government's share. *Id.*, at 85.

The Board reached the same conclusion, by the same means, in the Washington case. See *id.*, at 53-64.

Neither of these adjudications compels us to conclude that Arkansas' statutory lien comports with federal law. First, the Board's rulings address a different question from the one presented here. The Board was concerned with the Federal Government's obligation to reimburse States that had, in its view, failed to seek full recovery of Medicaid's costs and had instead relied on recipients to act as private attorneys general. The Board neither discussed nor even so much as cited the federal anti-lien provision.

Second, the Board's acknowledgment that the assignment of rights required by § 1396k(a) is limited to payments for medical care only reinforces the clarity of the statutory language. Moreover, its resort to "the statutory scheme as a whole" as justification for muddying that clarity is nowhere explained. Given that the only statutory provisions CMS relied on are §§ 1396a(a)(25), 1396k(a), and 1396k(b), see *id.*, at 75-76; *id.*, at 54-55, and given the Board's concession that the first two of these limit the State's assignment to payments for medical care, the "statutory scheme" must mean § 1396k(b). But that provision does not authorize the State to demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages; instead, it gives the State a priority disbursement from the medical expenses portion alone. See *supra*, at 1762. In fact, in its adjudication in the Washington case, the Board conceded as much: "[CMS] may require a state to assert a collection priority over funds obtained by Medicaid recipients in [third-party liability] suits *even though the distribution methodology*

set forth in section [1396k(b)] refers only to payments collected pursuant to assignments for medical care." App. to Pet. for Cert. 54 (emphasis added). The Board's reasoning therefore is internally inconsistent.

Third, the Board's reliance on legislative history is misplaced. The Board properly observed that Congress, in crafting the Medicaid legislation, intended that Medicaid be a "payer of last resort." S.Rep. No. 99-146, p. 313 (1985). That does not mean, however, that Congress meant to authorize States to seek reimbursement from Medicaid recipients themselves; in fact, with the possible exception of a lien on payments for medical care, the statute expressly prohibits liens against the property of Medicaid beneficiaries. See 42 U.S.C. § 1396p(a). We recognize that Congress has delegated "broad regulatory authority to the Secretary [of HHS] in the Medicaid area," *Wisconsin Dept. of Health and Family Servs. v. Blumer*, 534 U.S. 473, 496, n. 13, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002), and that agency adjudications typically warrant deference. Here, however, the Board's reasoning couples internal inconsistency with a conscious disregard for the statutory text. Under these circumstances, we decline to treat the agency's reasoning as controlling.

VII

Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-

party liability provisions are unenforceable insofar as they compel a different conclusion. The judgment of the Court of Appeals is affirmed.

It is so ordered.

APPENDIX E — EZELL v. GRACE HOSPITAL OF THE NORTH CAROLINA COURT OF APPEALS DATED DECEMBER 20, 2005 AND SUPREME COURT OF NORTH CAROLINA DATED JUNE 30, 2006

COURT OF APPEALS OF NORTH CAROLINA

No. COA04-721.

Dec. 20, 2005.

Pammy Austin EZELL as Guardian ad Litem of Michelle Lynn Morland, Plaintiff,

and

North Carolina Department of Health and Human Services, Division of Medical Assistance, Intervenor,

v.

GRACE HOSPITAL, INC., John F. Whalley, M.D. and Mountain View Pediatrics, P.A., Defendants.

HUDSON, Judge.

Plaintiff filed a medical malpractice suit against defendants Grace Hospital, Inc., John F. Whalley, M.D., and Mountain View Pediatrics, Inc., for alleged negligent medical care. The plaintiffs settled with the tort defendants and the Department of Health and Human Services, Division of Medical Assistance (DMA) intervened, seeking payment of its statutory Medicaid lien for payments it made on behalf of plaintiff, a Medicaid recipient. On 22 January 2004, the trial court

denied DMA's motion requesting payment of its full statutory Medicaid lien of one-third of the settlement amount, instead awarding DMA a lesser sum, amounting to a pro-rated share of treatment allegedly related to the defendants' negligence. DMA appeals.

Michelle Morland was born on 16 May 1998 at Grace Hospital in Morganton, North Carolina. Immediately following birth, she displayed signs of respiratory distress. Dr. John F. Whalley, a pediatrician, assumed care for her. After several hours of respiratory problems, she was transferred to another hospital for additional care. Several years later, Michelle Morland was diagnosed with Cerebral Palsy. Upon belief that Michelle's condition was caused by the respiratory difficulties she experienced after birth, Michelle's grandmother and guardian, Pammy Austin Ezell, filed a medical malpractice suit as Guardian Ad Litem for Michelle, against Dr. Whalley and Grace Hospital. From the time of her birth, Michelle Morland has been a recipient of Medicaid.

Early in the lawsuit, plaintiff and defendant Grace Hospital entered into a settlement agreement for $100,000 which is not at issue in this appeal. As discovery proceeded with the remaining defendants, deposition testimony revealed credible evidence by numerous experts that no causal link existed between the alleged negligence following birth and Michelle's cerebral palsy. Plaintiff thus entered into a second settlement with defendants Whalley and Mountain View Pediatrics, also in the amount of $100,000. At the 12 December 2004

hearing for judicial approval of the agreement, the trial court heard arguments from DMA that the settlement proceeds should be subject to a lien in favor of DMA for Medicaid payments made on behalf of Michele Morland. On the date of the hearing, the Medicaid lien totaled $86,840.92.

On 2 January 2004, Judge Robert C. Ervin approved the settlement but limited DMA's recovery to $8,054.01, the amount of medical expenses he determined to be causally related to the alleged negligence of defendants Whalley and Mountain View. On 22 January 2004, after hearing DMA's Motion for a New Hearing and to Intervene, Judge Ervin entered another order which clarified and upheld the terms of his previous approval. DMA appeals from Judge Ervin's 22 January 2004 order limiting DMA's subrogation rights to the proceeds obtained on behalf of plaintiff from defendants Whalley and Mountain View Pediatrics. In its brief, appellant first argues that the trial court committed reversible error in its application of common law principles of equity to the Division of Medical Assistance's right of subrogation. Appellant argues that N.C. Gen.Stat. § 108A-57(a)(2003) abrogates the equitable principles of subrogation. We agree. N.C. Gen.Stat. § 108A-57(a) provides as follows:

> Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance, or of the

> beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person . . . Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.

Id. (emphasis added). The trial court found that subrogation under N.C. Gen.Stat. § 108A-57 does not alter the common law application of principles of equity. Citing dictates of "equity, good conscience and *60 public policy," the trial court found that awarding DMA one-third of plaintiff's recovery would be unfair, resulting in plaintiff receiving less than ten percent of the settlement proceeds.

Our standard of review of the order of the superior court is de novo, as defendants have raised an issue of law. *Medina v. Div. of Soc. Servs.*, 165 N.C.App. 502, 505, 598 S.E.2d 707, 709 (2004), citing *Shear v. Stevens Building Co.*, 107 N.C.App. 154, 160, 418 S.E.2d 841, 845 (1992). In matters of statutory construction, this

Court must "ascertain and effectuate the intent of the legislative body." *Coastal Ready Mix Concrete Co. v. Board of Commissioners*, 299 N.C. 620, 629, 265 S.E.2d 379, 385 (1980). It is well-established that legislative intent may be determined from the language of the statute, and "if a statute is facially clear and unambiguous, leaving no room for interpretation, the courts will enforce the statute as written." *Haight v. Travelers/Aetna Property Casualty Corp.*, 132 N.C.App. 673, 675, 514 S.E.2d 102, 104 (1999). We conclude that plain language of the statute here precludes the application of equitable subrogation principles. We conclude that the legislature specifically abrogated the application of common law principles of equity when it stated that the State "shall be subrogated to all rights of recovery," "notwithstanding any other provisions of the law." N.C. Gen.Stat. § 108A-57(a). Although our Supreme Court has held that subrogation is "a creature of equity," designed to prevent injustice, *General Ins. Co. of Am. v. Faulkner*, 259 N.C. 317, 324, 130 S.E.2d 645, 651 (1963), we must enforce the statute as written and if the legislature wishes for common law equitable principles to apply to this statute, it may certainly amend it accordingly.

Appellant also argues that the trial court erred in finding that DMA's recovery should be limited to the amount it paid for medical services that corresponded to defendants' alleged negligence. We disagree. In its brief, appellant argues that "North Carolina law entitles the State to full reimbursement for any Medicaid payments made on a plaintiff's behalf in the event the

plaintiff recovers an award for damages." (emphasis added). However, we conclude that the plain language of the statute, which gives the State subrogation rights to proceeds obtained from a third-party "by reason of injury or death," indicates an intent to limit that subrogation right to the amount resulting from such injury or death. N.C. Gen.Stat. § 108A-57 (a). Indeed, in a 24 November 2003 letter to plaintiffs regarding the amount of the Medicaid lien, an assistant chief of the third party recovery section of DMA stated that Medicaid must be reimbursed for "medical care and services needed as a result of [plaintiff's] injury." Appellant cites *Cates v. Wilson*, 321 N.C. 1, 361 S.E.2d 734 (1987), *Campbell v. N.C. Dep't of Human Res.*, 153 N.C.App. 305, 569 S.E.2d 670 (2002), and *Payne v. N.C. Dept. of Human Res.*, 126 N.C.App. 672, 486 S.E.2d 469, *disc. review denied*, 347 N.C. 269, 493 S.E.2d 656 (1997), in support of its position, but none of these cases involved the issue of causation or whether damages may be apportioned according to the amounts paid which were related to the injuries.

The legislature surely did not intend that DMA could recoup for medical treatment unrelated to the injury for which the beneficiary received third-party recovery. Without a requirement of a causal nexus between the DMA lien and a Medicaid beneficiary's third-party recovery, DMA could theoretically do so. For example, under the interpretation encouraged by Appellant, if a Medicaid beneficiary received treatment for cancer, and later received treatment for injuries sustained in a car accident for which she recovered

damages from a third-party, DMA could impose a lien for the cancer treatment as well as for the injuries related to the accident. This would allow DMA unlimited subrogation rights to a beneficiary's proceeds obtained from a third-party, rather than to those proceeds obtained "by reason of injury or death," as specified in N.C. Gen.Stat. § 108A-57(a).

Appellant also argues that reducing DMA's lien is contrary to federal Medicaid law. We disagree. It is undisputed that Federal law requires the State to collect money from third party tortfeasors liable to Medicaid beneficiaries. 42 U.S.C.A. § 1396a(a)(25) provides:

> A State plan for medical assistance must provide:
>
> * * * *
>
> (A) that the State or local agency administering such plan will take all reasonable measures to ascertain *the legal liability of third parties*(including health insurers) *to pay for care and service* available under the plan, including–
>
> * * * *
>
> (B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the

> individual . . . the State or local agency will seek reimbursement for such assistance *to the extent of such legal liability.*

Id. (emphasis added). This Court in *Payne* correctly read the federal statute to require the State "to take measures to determine the legal liability of third parties and to seek reimbursement from them." *Payne* at 676, 486 S.E.2d 469. However, the federal statute does not require the State to seek reimbursement for a certain amount, or percentage, of a recipient's recovery. See *Smith v. Alabama Medicaid Agency,* 461 So.2d 817, 820 (Ala.Civ.App.1984) (holding that 42 U.S.C. § 1396a(a)(25) does not "specifically require or even suggest 100% recovery"). We read the statute here as requiring reimbursement only to the extent of the third party's legal liability for injuries resulting in "care and service" paid by Medicaid. The federal statute specifies that the legal liability for which the State should seek reimbursement is "the legal liability . . . to pay for care and services." 42 U.S.C.A. § 1396a(a)(25)(A).

Although we conclude that N.C. Gen.Stat. § 108A-57 (a) limits DMA's subrogation rights to the injury for which the beneficiary received third-party recovery, we also conclude that the trial court's findings here regarding causation are not supported by competent evidence. The court found the following:

> 7. The Court finds that Michelle Morland suffered injury at birth from a delay in treating her respiratory distress and this

comprises the major portion of her existing claim. Michelle Morland received treatment at Grace Hospital for these injuries.

* * *

12. Of the full Medicaid lien for funds expended for the minor, $66,666.66, the Plaintiff contends, and the Court agrees and so finds, that only $8,054.01 is causally related to Defendants [sic] alleged negligence.

However, our careful review of the record reveals no competent evidence to support these findings. The deposition testimony provided in the record establishes that defendants' alleged negligence did not cause plaintiff's cerebral palsy but does not address what other injury, if any, was caused by defendants' actions, nor does it establish that there was any negligence. In the consent judgment and order approving settlement, both the plaintiff and defendant Grace Hospital consented to the following finding of fact:

2. This action involves the alleged medical negligence of Defendants which are alleged to have caused permanent physical and psychological injury to Michelle Lynn Moriand that has necessitated medical care and treatment, and which, the Plaintiff alleges, will

> require medical care and treatment for the remainder of Michelle Lynn Morland's life. *The Defendants have denied these allegations.*

(emphasis added). Although plaintiff asserted a causal connection between the alleged negligence and Medicaid payments of $8,054.01, in its petition for judicial approval of the settlement, no evidence of record supports this contention. Accordingly, we vacate and remand for further proceedings, and specifically for new findings, if any, regarding what proceeds plaintiff obtained "by reason of injury or death," and thus, what portion of plaintiff's award are subject to DMA's right of subrogation.

Appellant also contends that the trial court committed reversible error in presuming that the proceeds were the property of the plaintiff. N.C. Gen.Stat. § 108A-59 provides that, as a condition of Medicaid eligibility, a Medicaid recipient must assign to the State "the right to third party benefits, contractual or otherwise, to which he may be entitled." However, the trial court acknowledged DMA's right to recovery by subrogation and made no finding or conclusion that the proceeds were the "property of the plaintiff." Because we conclude that the court did not apply such a presumption, we overrule this assignment of error.

Finally, appellants argue that the trial court committed reversible error in its failure to follow public policy. Appellants assert that Medicaid was intended to

be the payor of last resort and that the subrogation statutes are designed to replenish Medicaid funds when a recipient recovers from a tortfeasor. We do not disagree that these policy considerations underlie the subrogation statutes, however, as discussed, we conclude that the statute requires that DMA's subrogation rights be limited to proceeds obtained "by reason of injury."

For the reasons discussed above, we vacate the court's order and remand for further findings in accordance with this opinion.

Vacated and remanded.

Judge WYNN concurs.

Judge STEELMAN concurs in part and dissents in part.

STEELMAN, Judge concurring in part and dissenting in part.

I concur in those portions of the majority's opinion dealing with equitable subrogation and holding that the trial court did not apply a presumption that the settlement proceeds were the property of plaintiff. However, I must respectfully dissent as to the remainder of the opinion.

In *Cates v. Wilson,* our Supreme Court stated, "North Carolina law entitles the state to full reimbursement for any Medicaid payments made on a plaintiff's behalf in the event the plaintiff recovers an award for damages." 321 N.C. 1, 6, 361 S.E.2d 734, 738 (1987). In *Campbell v. N.C. Dep't of Human Res.,* this Court held it was irrelevant whether a settlement compensated a plaintiff for medical expenses because "N.C. Gen.Stat. § 108A-57(a) does not restrict defendant's right of subrogation to a beneficiary's right of recovery only for medical expenses." 153 N.C.App. 305, 307, 569 S.E.2d 670, 672 (2002). The applicable portion of the statute dealing with the scope of DMA's right of subrogation reads as follows:

> Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical

> assistance benefits, shall be subrogated to **all rights of recovery, contractual or otherwise,** of the beneficiary of this assistance, or of the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. . . .

N.C. Gen.Stat. § 108A-57(a) (2005) (emphasis added).

The above language contemplates a broad right of subrogation, which is indicated by the reference to "all rights of recovery." Subrogation is not limited to tort recovery, as the statute expressly covers contractual rights or "otherwise." *See State v. Shade,* 115 N.C. 757, 759, 20 S.E. 537, 537 (1894) (noting that when the words "or otherwise," follows an explicit example in a statute, the legislature intends to include every other manner of fulfilling the purpose of the statute, for example here, recovery, no matter what might be the attendant circumstances). The causation language discussed by the majority is from the portion of the statute dealing with the duty of a plaintiff's attorney to distribute settlement proceeds to DMA, not from the portion of the statute defining the scope of DMA's right of subrogation, which is set forth *verbatim* above. The punctuation of the statute gives further credence to this interpretation. The provisions in the statute are set apart by periods, not commas or semicolons. This indicates their separateness. *See Stephens Co. v. Lisk,* 240 N.C. 289, 294, 82 S.E.2d 99, 102 (1954) ("There is no reason why punctuation, which is intended to and does assist in making clear and plain all things else in the

English language, should be rejected in the case of interpretation of statutes") (citations and internal quotation marks omitted). In light of these principles of statutory construction, I do not read the scope of DMA's right of subrogation as narrowly as the majority.

By remanding this matter to the trial court, the majority is expressly authorizing the trial court to find that if there is not a "causal connection" between an actual injury suffered by plaintiff as a result of Dr. Whalley's medical negligence and the medical bills paid by DMA, the trial court can reduce the amount of DMA's lien below the one-third provided for in N.C. Gen.Stat. § 108A-57(a) and this state's prior case law.

I agree with the majority that no DMA lien would attach to proceeds of a settlement from an automobile accident for Medicaid payments for unrelated cancer treatments. However, that is not the case before this Court.

Plaintiff's complaint alleged:

> 27. That as a direct and proximate result of the deviations of the standard of care from and by Defendant Whalley recited herein, Michelle Morland suffered extensive, severe and permanent neurologic and physical damage, including cerebral palsy, which has been directly associated with the Defendant's negligence.

The basis of the suit was a single claim for medical negligence resulting in plaintiff suffering cerebral palsy, a catastrophic condition. The $100,000.00 settlement with Dr. Whalley is a direct result of that lawsuit. This conclusion is unaltered by the fact that during discovery plaintiff realized Dr. Whalley was not as negligent as was originally believed. The settlement with Dr. Whalley was for a single lump-sum of $100,000.00.

Our cases have consistently rejected attempts by plaintiffs to characterize portions of settlements as being for medical bills or for pain and suffering in order to circumvent DMA's statutory lien. *See Campbell,* 153 N.C.App. 305, 569 S.E.2d 670; *Payne v. N.C. Dept. of Human Resources,* 126 N.C.App. 672, 486 S.E.2d 469, *disc. review denied,* 347 N.C. 269, 493 S.E.2d 656 (1997). The majority would resurrect this practice through a very narrow reading of DMA's subrogation right.

This Court's decision in *Payne,* 126 N.C.App. 672, 486 S.E.2d 469, provides guidance on this issue. In *Payne,* DMA had a statutory lien in the amount of $138,198.53. The plaintiff settled his claim for one million dollars, allocated $45,000 of this amount for medical bills, and asserted that DMA was only entitled to one-third of that amount. This Court ordered that DMA was entitled to recover the full amount of its lien of $138,198.53 from the plaintiff. *Id.* at 677, 486 S.E.2d at 471.

Payne highlights the problem which arises if the courts allow a plaintiff to characterize the nature of the

settlement proceeds, whether by denominating them for medical bills or not for medical bills, as was the case in *Payne*, or causally related to the third-party recovery as posited by the majority in this case. Both devices are designed to circumvent DMA's statutory right of subrogation and to place more of the recovery in the hands of the plaintiff. However sympathetic one may be to the plaintiff's plight in this case, such a result is contrary to the law of this state.

DMA's right of subrogation under N.C. Gen.Stat. § 108A-57(a) is broad rather than narrow. Even assuming the majority's narrow causation test is proper, any causal connection required for purposes of this statute was satisfied when plaintiff obtained a settlement as a direct result of filing the medical negligence action against Dr. Whalley.

I would hold that DMA is subrogated to the entire amount of the $100,000.00 settlement and is entitled to receive one-third of that amount as partial payment of its $86,540.92 lien.

Appendix E

SUPREME COURT OF NORTH CAROLINA

No. 44A06.

June 30, 2006.

Pammy Austin EZELL as Guardian ad Litem of Michelle Lynn Morland,

and

North Carolina Department of Health and Human Services, Division of Medical Assistance, Intervenor

v.

GRACE HOSPITAL, INC., John F. Whalley, M.D., and Mountain View Pediatrics, P.A.

PER CURIAM.

For the reasons stated in the dissenting opinion, the decision of the Court of Appeals is reversed. This case is remanded to the Court of Appeals for further remand to the trial court for further proceedings not inconsistent with this opinion.

REVERSED AND REMANDED.

APPENDIX F — UNITED STATES CONSTITUTION EXCERPTS: U.S. CONST. ART. VI, CLAUSE 2

U.S.C.A. Const. Art. VI cl.2:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

APPENDIX G — UNITED STATES CODE EXCERPTS: 42 U.S.C. § 1396a 42 U.S.C. § 1396k 42 U.S.C. § 1996p

42 U.S.C. § 1396a

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

* * *

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of

recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency,

* * *

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid, [7] transfers of assets, and treatment of certain trusts;

* * *

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 1167(1) of Title 29), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to

pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396*o* of this title), or (ii) in an amount which exceeds the lesser of

(I) the amount which may be collected under section 1396*o* of this title, or

(II) the amount by which the amount payable for that service under the plan (disregarding section 1396*o* of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under

the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

* * *

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made

(i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or

(ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed

(i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or

(ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

Appendix G

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer

(i) supplies doses of the vaccine to providers administering the vaccine,

(ii) periodically replaces the supply of the vaccine, and

(iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

Appendix G

42 U.S.C.A 1396k

§ 1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person,

unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396p

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical

institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan.

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter

that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of Title 26) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported

electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B) of this section, when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual

to reside at home rather than in an institution), is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

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(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(c)—

(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market

value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

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(C)(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after

which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this title; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless—

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of section 408 of Title 26; or

(II) purchased with proceeds from—

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such title;

(bb) a simplified employee pension (within the meaning of section 408(k) of such title); or

(cc) a Roth IRA described in section 408A of such title; or

(ii) the annuity—

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (b), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual.

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While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust—

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.

(B) In the case of an irrevocable trust—

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section; and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter, and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e)(1) In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) of this section (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F) of this section, the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f)(1)(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title

(relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

Appendix G

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect

to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii) of this section.

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.

APPENDIX H — CODE OF FEDERAL REGULATIONS EXCERPTS:
42 C.F.R. § 430.0
42 C.F.R. § 430.35
42 C.F.R. § 433.140
42 C.F.R. § 447.302

42 C.F.R. § 430.0

§ 430.0 Program description.

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

Appendix II

42 C.F.R. § 430.35

§ 430.35 Withholding of payment for failure to comply with Federal requirements.

(a) Basis for withholding. CMS withholds payments to the State, in whole or in part, only if, after giving the agency reasonable notice and opportunity for a hearing in accordance with subpart D of this part, the Administrator finds—

(1) That the plan no longer complies with the provisions of section 1902 of the Act; or

(2) That in the administration of the plan there is failure to comply substantially with any of those provisions.

Appendix H

42 C.F.R. § 433.140

§ 433.140 FFP and repayment of Federal share.

(a) FFP is not available in Medicaid payments if—

(1) The agency failed to fulfill the requirements of §§ 433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;

(2) The agency received reimbursement from a liable third party; or

(3) A private insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid.

(b) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart.

(c) If the State receives FFP in Medicaid payments for which it receives third party reimbursement, the State must pay the Federal government a portion of the reimbursement determined in accordance with the FMAP for the State. This payment may be reduced by the total amount needed to meet the incentive payment in § 433.153.

Appendix H

42 C.F.R. 447.302

§ 447.302 State plan requirements.

A State plan must provide that the requirements of this subpart are met.

APPENDIX I — NORTH CAROLINA GENERAL STATUTES:
N.C. GEN. STAT. § 108A-56
N.C. GEN. STAT. § 108A-57
N.C. GEN. STAT. § 108A-59

N.C. GEN. STAT. § 108A-56

§ 108A-56. Acceptance of federal grants

All of the provisions of the federal Social Security Act providing grants to the states for medical assistance are accepted and adopted, and the provisions of this Part shall be liberally construed in relation to such act so that the intent to comply with it shall be made effectual. Nothing in this Part or the regulations made under its authority shall be construed to deprive a recipient of assistance of the right to choose the licensed provider of the care or service made available under this Part within the provisions of the federal Social Security Act.

Appendix I

N.C. GEN. STAT. § 108A-57

§ 108A-57. Subrogation rights; withholding of information a misdemeanor

(a) Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance, or of the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. The county attorney, or an attorney retained by the county or the State or both, or an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made under this Part shall enforce this section. Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.

The United States and the State of North Carolina shall be entitled to shares in each net recovery under this section. Their shares shall be promptly paid under

this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

Appendix I

N.C. GEN. STAT. § 108A-59

§ 108A-59. Acceptance of medical assistance constitutes assignment to the State of right to third party benefits; recovery procedure

(a) Notwithstanding any other provisions of the law, by accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which he may be entitled.

It shall be the responsibility of the county attorney of the county from which the medical assistance benefits are received or an attorney retained by that county and/or the State to enforce this subsection, and said attorney shall be compensated for his services in accordance with the attorneys' fee arrangements approved by the Department of Health and Human Services.

(b) The responsible State agency will establish a third party resources collection unit that is adequate to assure maximum collection of third party resources.

(c) Notwithstanding any other law to the contrary, in all actions brought pursuant to subsection (a) of this section to obtain reimbursement for payments for medical services, liability shall be determined on the basis of the same laws and standards, including bases for liability and applicable defenses, as would be applicable if the action were brought by the individual on whose behalf the medical services were rendered.

APPENDIX J — ARKANSAS CODE: ARK. CODE ANN. § 20-77-302 ARK. CODE ANN. § 20-77-307

§ 20-77-302. Claim by recipient

(a) When an action or claim is brought by a medical assistance recipient or his or her legal representative against a third party who may be liable for injury, disease, disability, or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the division's claim for reimbursement of the benefits provided to the recipient under the medical assistance program.

(b) In the event of judgment or award in a suit or claim against a third party, if the action or claim is prosecuted by the recipient alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses and attorney's fees. After the payment of these expenses and attorney's fees, the court or agency shall order that the Department of Human Services receive an amount sufficient to reimburse the department the full amount of benefits paid on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.

Appendix J

ARK. CODE ANN. § 20-77-307

§ 20-77-307. Medicaid; assignment of rights

(a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.

(b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.

(c) The assignment shall be considered a statutory lien on any settlement, judgment, or award received by the recipient from a third party.

(d) Every Medicaid applicant, as a condition of eligibility, shall cooperate in establishing paternity, except for good cause shown, for a child born out of wedlock for whom the recipient can legally assign rights, in obtaining medical care, support, and payments for himself or herself or any other person for whom the individual can legally assign rights, and in identifying and providing information to assist the department and the Office of Child Support Enforcement in pursuing any liable third party.

APPENDIX K — 62 P.S. 1409
62 P.S. 1409.1

62 P.S. § 1409

§ 1409. Third party liability

(a)(1) No person having private health care coverage shall be entitled to receive the same health care furnished or paid for by a publicly funded health care program. For the purposes of this section, "publicly funded health care program" shall mean care for services rendered by a State or local government or any facility thereof, health care services for which payment is made under the medical assistance program established by the department or by its fiscal intermediary, or by an insurer or organization with which the department has contracted to furnish such services or to pay providers who furnish such services. For the purposes of this section, "privately funded health care" means medical care coverage contained in accident and health insurance policies or subscriber contracts issued by health plan corporations and nonprofit health service plans, certificates issued by fraternal benefit societies, and also any medical care benefits provided by self insurance plan including self insurance trust, as outlined in Pennsylvania insurance laws and related statutes.

(2) If such a person receives health care furnished or paid for by a publicly funded health care program, the insurer of his private health care coverage shall reimburse the publicly funded health care program, the cost incurred in rendering such care to the extent of the benefits provided under the terms of the policy for the services rendered.

(3) Each publicly funded health care program that furnishes or pays for health care services to a recipient having private health care coverage shall be entitled to be subrogated to the rights that such person has against the insurer of such coverage to the extent of the health care services rendered. Such action may be brought within five years from the date that service was rendered such person.

(4) When health care services are provided to a person under this section who at the time the service is provided has any other contractual or legal entitlement to such services, the secretary of the department shall have the right to recover from the person, corporation, or partnership who owes such entitlement, the amount which would have been paid to the person entitled thereto, or to a third party in his behalf, or the value of the service actually provided, if the person entitled thereto was entitled to services. The Attorney General may, to recover under this section, institute and prosecute legal proceedings against the person, corporation, health service plan or fraternal society owing such entitlement in the appropriate court in the name of the secretary of the department.

(5) The Commonwealth of Pennsylvania shall not reimburse any local government or any facility thereof, under medical assistance or under any other health program where the Commonwealth pays part or all of the costs, for care provided to a person covered under any disability insurance, health insurance or prepaid health plan.

(6) In local programs fully or partially funded by the Commonwealth, Commonwealth participation shall be reduced in the amount proportionate to the cost of services provided to a person.

(7) When health care services are provided to a dependent of a legally responsible relative, including but not limited to a spouse or a parent of an unemancipated child, such legally responsible relative shall be liable for the cost of health care services furnished to the individual on whose behalf the duty of support is owed. The department shall have the right to recover from such legally responsible relative the charges for such services furnished under the medical assistance program.

(b)(1) When benefits are provided or will be provided to a beneficiary under this section because of an injury for which another person is liable, or for which an insurer is liable in accordance with the provisions of any policy of insurance issued pursuant to Pennsylvania insurance laws and related statutes the department shall have the right to recover from such person or insurer the reasonable value of benefits so provided. The Attorney General or his designee may, at the request of the department, to enforce such right, institute and prosecute legal proceedings against the third person or insurer who may be liable for the injury in an appropriate court, either in the name of the department or in the name of the injured person, his guardian, personal representative, estate or survivors.

(2) The department may:

(i) compromise, or settle and release any such claims; or

(ii) waive any such claim, in whole or in part, or if the department determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(3) No action taken in behalf of the department pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, personal representative, estate, dependents or survivors against the third person who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

(4)(i) Where an action is brought by the department pursuant to this section, it shall be commenced within seven years of the date the cause of action arises:

(ii) Notwithstanding subclause (i), if a beneficiary has commenced an action to recover damages for an injury for which benefits are provided or will be provided and if the department was not provided with adequate notice under this section or *section 1409.1*, the department may commence an action under this section within the later of seven years of the date the cause of action arises or

two years from the date the department discovers the settlement or judgment. Notice shall be adequate if all of the following notices have been provided to the department, if required:

(A) Notice of suit under clause (5)(i) from either the beneficiary or any third party or insurer.

(B) Notice of any election from the beneficiary under clause (5)(iii).

(C) Notice of settlement under clause (5)(iv) from either the beneficiary or any third party or insurer.

(D) Notice of any allocation proceeding under *section 1409.1(b)(3).*

(iii) The following shall apply:

(A) The death of the beneficiary does not abate any right of action established by this section.

(B) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the department's claims for reimbursement of the benefits provided to the beneficiary under the medical assistance program.

(C) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal

liability to pay attorney's fees and costs of litigation, the department's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the medical expenditures for the services to the beneficiary.

(D) Where benefits are provided or will be provided for a minor's care, any statute of limitation or repose applicable to an action or claim in which the minor's medical expenses may be sought shall be tolled until the minor reaches the age of majority. The period of minority shall not be deemed a portion of the time period within which the action must be commenced. As used in this clause, the term "minor" shall mean any individual who has not yet attained the age of 18.

(5) If either the beneficiary or the department brings an action or claim against such third party or insurer, the beneficiary or the department shall within thirty days of filing the action give to the other written notice by personal service or by certified or registered mail of the action or claim. Any third party or insurer that has received information indicating that the beneficiary received benefits under the medical assistance program shall give written notice to the department by personal service or by certified or registered mail of the action or claim. Proof of the notices shall be filed in the action or claim.

(i) If a beneficiary files an action or claim that does not seek recovery of expenses for which benefits under the medical assistance program are provided, the

beneficiary shall include in the notice to the department a statement that the action or claim does not seek recovery of the expenses.

(ii) If a parent files an action or claim that does not seek recovery of a minor's medical expenses paid by the medical assistance program, the parent shall include in the notice to the department a statement that the action or claim does not seek the recovery of the expenses.

(iii) If a beneficiary files an action or claim that seeks the recovery of expenses for which benefits under the medical assistance program are provided and later elects not to seek recovery of the expenses, the beneficiary shall provide reasonable notice to the department by personal service or by certified or registered mail. Notice shall be reasonable if it allows the department sufficient time to petition to intervene in the action and prosecute its claim.

(iv) Notice of any settlement shall be provided to the department by the beneficiary and any third party or insurer within thirty days of the settlement. Where judicial approval of the settlement is required, reasonable notice of the settlement shall be provided to the department before a judicial hearing for approval of the settlement. Notice is reasonable if it allows the department sufficient time to intervene in the action and prosecute its claim.

(v) If an action or claim is brought by either the department or beneficiary, the other may, at any time

before trial on the facts, become a party to or shall consolidate his action or claim with the other if brought independently.

(vi) The beneficiary may include as part of his claim the amount of benefits that have been or will be provided by the medical assistance program.

(6) If an action or claim is brought by the department pursuant to subsection (b)(1), written notice to the beneficiary given pursuant to this section shall advise him of his right to intervene in the proceeding and his right to recover the reasonable value of the benefits provided.

(7) Except as provided under section 1409.1, in the event of judgment, award or settlement in a suit or claim against such third party or insurer:

(i) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses, as determined by the court, incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of such expenses and attorney's fees the court or agency shall, on the application of the department, allow as a first lien against the amount of such judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program.

(ii) If the action or claim is prosecuted both by the beneficiary and the department, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of such expenses and attorney's fees, the court or agency shall apply out of the balance of such judgment or award an amount of benefits paid on behalf of the beneficiary under the medical assistance program.

(iii) With respect to claims against third parties for the cost of medical assistance services delivered through a managed care organization contract, the department shall recover the actual payment to the hospital or other medical provider for the service. If no specific payment is identified by the managed care organization for the service, the department shall recover its fee schedule amount for the service.

(8) Except as provided under *section 1409.1*, upon application of the department, the court or agency shall allow a lien against any third party payment or trust fund resulting from a judgment, award or settlement in the amount of any expenditures in payment of additional benefits arising out of the same cause of action or claim provided on behalf of the beneficiary under the medical assistance program, when such benefits were provided or became payable subsequent to the date of the judgment, award or settlement.

(9) Unless otherwise directed by the department, no payment or distribution shall be made to a claimant or a claimant's designee of the proceeds of any action, claim or settlement where the department has an interest without first satisfying or assuring satisfaction of the interest of the Commonwealth. Any person who, after receiving notice of the department's interest, knowingly fails to comply with the obligations established under this clause shall be liable to the department, and the department may sue to recover from the person.

(10) When the department has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the medical assistance program, the department shall be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the department shall be entitled to a writ of execution against such beneficiary to the extent of the department's lien, with interest and other accruing costs as in the cost of other executions.

(11) Except as otherwise provided in this act, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the department's claim for reimbursement of the benefits provided any lien filed pursuant thereto, but in no event shall the department's claim exceed one-half of the

beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary.

(12) In the event that the beneficiary, his guardian, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by this act shall be given to the secretary (or his designee) in Harrisburg except in cases where the secretary specifies that notice shall be given to the Attorney General. The beneficiary's obligations under this subsection shall be met by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, personal representative, estate or survivors, if no attorney is retained.

(13) The following special definitions apply to this subsection:

"Beneficiary" means any person who has received benefits or will be provided benefits under this act because of an injury for which another person may be liable. It includes such beneficiary's guardian, conservator, or other personal representative, his estate or survivors.

"Insurer" includes any insurer as defined in the act of May 17, 1921 (P.L. 789, No. 285), [1] known as "The

1. *40 P.S. § 1 et seq.*

Appendix K

Insurance Department Act of one thousand nine hundred and twenty-one," including any insurer authorized under the Laws of this Commonwealth to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement of coverage pursuant to the act of July 19, 1974 (P.L. 489, No. 176), [2] known as the "Pennsylvania No-fault Motor Vehicle Insurance Act."

(c) Following notice and hearing, the department may administratively impose a penalty of up to five thousand dollars ($5,000) per violation upon any person who wilfully fails to comply with the obligations imposed under this section.

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2. *40 P.S. § 1009.101* to *1009.701* (repealed); see now, *75 Pa.C.S.A. 1701 et seq.*

Appendix K

62 P.S. § 1409.1

§ 1409.1. Federal law recovery of medical assistance reimbursement

(a) To the extent that Federal law limits the department's recovery of medical assistance reimbursement to the medical portion of a beneficiary's judgment, award or settlement in a claim against a third party, the provisions of this section shall apply.

(b) In the event of judgment, award or settlement in a suit or claim against a third party or insurer:

(1) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses, as determined by the court, incurred in preparation and prosecution of the action or claim, together with reasonable attorney fees. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall allow the department a first lien against the medical portion of the judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program.

(2) If the action or claim is prosecuted both by the beneficiary and the department, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation

and prosecution of the action or claim, together with reasonable attorney fees based solely on the services rendered for the benefit of the beneficiary. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall make an award to the department out of the medical portion of the judgment or award the amount of benefits paid on behalf of the beneficiary under the medical assistance program.

(3) The department shall be given reasonable advance notice before the court makes any allocation of a judgment or award under this section.

(4) The provisions of *section 1409(b)(7)(iii)* shall apply to this section.

APPENDIX L — CA WEL & INST. § 14124.76 CA WEL & INST. § 14124.78

California Code, Welfare and Institution Code

CA WEL & INST. § 14124.76

§ 14124.76.

(a) No settlement, judgment, or award in any action or claim by a beneficiary to recover damages for injuries, where the director has an interest, shall be deemed final or satisfied without first giving the director notice and a reasonable opportunity to perfect and to satisfy the director's lien. Recovery of the director's lien from an injured beneficiary's action or claim is limited to that portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. All reasonable efforts shall be made to obtain the director's advance agreement to a determination as to what portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided of behalf on the beneficiary. Absent the director's advance agreement as to what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary, the matter shall be submitted to a court for decision. Either the director or the beneficiary may seek resolution of the dispute by filing a motion, which shall be subject to regular law and motion procedures. In determining what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf

of the beneficiary and as to what the appropriate reimbursement amount to the director should be, the court shall be guided by the United States Supreme Court decision in *Arkansas Department of Health and Human Services v. Ahlborn (2006) 547 U.S. 268* and other relevant statutory and case law.

(b) If the beneficiary has filed a third-party action or claim, the court where the action or claim was filed shall have jurisdiction over a dispute between the director and the beneficiary regarding the amount of a lien asserted pursuant to this section that is based upon an allocation of damages contained in a settlement or compromise of the third-party action or claim. If no third-party action or claim has been filed, any superior court in California where venue would have been proper had a claim or action been filed shall have jurisdiction over the motion. The motion may be filed as a special motion and treated as an ordinary law and motion proceeding and subject to regular motion fees. The reimbursement determination motion shall be treated as a special proceeding of a civil nature pursuant to Part 3 (commencing with *Section 1063) of the Code of Civil Procedure.* When no action is pending, the person making the motion shall be required to pay a first appearance fee. When an action is pending, the person making the motion shall pay a regular law and motion fee. Notwithstanding *Section 1064 of the Code of Civil Procedure,* either the beneficiary or the director may appeal the final findings, decision, or order.

(c) The court shall issue its findings, decision, or order, which shall be considered the final determination of the parties' rights and obligations with respect to the director's lien, unless the settlement is contingent on an acceptable allocation of the settlement proceeds, in which case, the court's findings, decision, or order shall be considered a tentative determination. If the beneficiary does not serve notice of a rejection of the tentative determination, which shall be based solely upon a rejection of the contingent settlement, within 30 days of the notice of entry of the court's tentative determination, subject to further consideration by the court pursuant to subdivision (d), the tentative determination shall become final. Notwithstanding *Section 1064 of the Code of Civil Procedure*, either the beneficiary or the director may appeal the final findings, decision, or order.

(d) If the beneficiary does not accept the tentative determination, which shall be based solely upon a rejection of the contingent settlement, any party may subsequently seek further consideration of the court's findings upon application to modify the prior findings, decision, or order based on new or different facts or circumstances. The application shall include an affidavit showing what application was made before, when, and to what judge, what order or decision was made, and what new or different facts or circumstances, including a different settlement, are claimed to exist. Upon further consideration, the court may modify the allocation in the interest of fairness and for good cause.

Appendix L

CA WEL & INST. § 14124.78

Notwithstanding any other provision of law, in no event shall the director recover more than the beneficiary recovers after deducting, from the settlement, judgment, or award, attorney's fees and litigation costs paid for by the beneficiary. If the director's recovery is determined under this section, the reductions in subdivision (d) of Section 14124.72 shall not apply.

APPENDIX M — MINUTES OF THE MEETING OF THE ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES, SEVENTY-FOURTH SESSION DATED MAY 2, 2007

MINUTES OF THE MEETING OF THE ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Fourth Session
May 2, 2007

The Committee on Health and Human Services was called to order by Vice Chair Susan I. Gerhardt at 1:38 p.m., on Wednesday, May 2, 2007, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (*Exhibit A*), the Attendance Roster (*Exhibit B*), and other substantive exhibits are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/74th/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

Appendix M

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sheila Leslie, Chair
Assemblywoman Susan I. Gerhardt, Vice Chair
Assemblyman Bob L. Beers
Assemblyman Joseph P. (Joe) Hardy
Assemblywoman Ellen Koivisto
Assemblywoman Kathy McClain
Assemblywoman Bonnie Parnell
Assemblywoman Peggy Pierce
Assemblyman Lynn D. Stewart
Assemblywoman Valerie E. Weber
Assemblywoman RoseMary Womack

GUEST LEGISLATORS PRESENT:

Senator Terry Care, Clark County Senatorial District No.7
Senator Dina Titus, Clark County Senatorial District No. 7

STAFF MEMBERS PRESENT:

Sarah J. Lutter, Committee Policy Analyst
Katrina Zach, Committee Secretary
Olivia Lloyd, Committee Assistant

Appendix M

OTHERS PRESENT:

Laura Hale, Social Services Chief, Grants Management Unit, Director's Office, Department of Health and Human Services

Liz MacMenamin, Director of Government Affairs, Retail Association of Nevada

Conrad Hafen, Senior Deputy Attorney General, Office of the Attorney General

Michelle Clayton, Legislative Counsel, National Conference of Commissioners on Uniform State Laws

Ken Richardson, Executive Director, Nevada Donor Network

Lawrence Matheis, Executive Director, Nevada State Medical Association,

Terence Ma, Director of Technology, Touro University Nevada

Clay Thomas, Deputy Director, Department of Motor Vehicles

Charles Duarte, Administrator, Division of Health Care Finance and Policy, Department of Health and Human Services

Sabrina Raetz, Deputy Attorney General, Office of the Attorney General

Renny Ashleman, representing Nevada Health Care Association

Matthew L. Sharp, representing Nevada Trial Lawyers Association

Appendix M

Vice Chair Gerhardt:
The Committee will come to order. [Roll.] We will begin with *Senate Bill 83.*

Senate Bill 83: **Revises provisions governing the Grants Management Advisory Committee of the Department of Health and Human Services. (BDR 18-593)**

Laura Hale, Social Services Chief, Grants Management Unit, Director's Office, Department of Health and Human Services:

Senate Bill 83 will allow flexibility regarding appointments to the Grants Management Advisory Committee. We had difficulty getting full membership, so we want to change the language to allow designees to represent local social services. We want designated people to participate in the place of a director or superintendent. The amendment states the superintendent of a county or the director of a local agency appoints the designee. This is one of the many bills that affect the Grants Management Unit, and it is my understanding there is an effort to incorporate these changes with *Assembly Bill 182,* which deals with the Fund for a Healthy Nevada.

Vice Chair Gerhardt:
I am concerned about the individuals that will be removed from the Grants Management Advisory Committee. I am curious why there will no longer be a representative from the Department of Juvenile Justice.

Appendix M

Laura Hale:
It is difficult to find a person to fill a specific position. Fernando Serrano was on the advisory committee, but when he became head of the Division of Child and Family Services, he had to leave the committee. The bill will make requirements for appointments more broad.

Vice Chair Gerhardt:
There was no mechanism for appointing someone in his place?

Laura Hale:
We did that, but it is simply a matter of making it more broad. If we cannot find a specific representative, then we can appoint someone with similar experience.

Vice Chair Gerhardt:
Not being allowed to rely on someone with a certain expertise is my only concern.

Laura Hale:
We replaced Mr. Serrano with a representative from the Department of Juvenile Justice.

Vice Chair Gerhardt:
What is the category?

Laura Hale:
Do mean under the new language?

Vice Chair Gerhardt:
Yes.

Laura Hale:
The person would have knowledge, skill, and experience in the provision of services to children.

Vice Chair Gerhardt:
Is that under the broader language?

Laura Hale:
Yes.

Assemblywoman McClain:
There were seven bills dealing with Fund for a Healthy Nevada. I combined five of those bills to make *Assembly Bill 182*. We combined *S.B. 83* in that bill because the bill changed the management of the Grants Management Advisory Committee. There are three other bills that are in drafting.

Vice Chair Gerhardt:
Did we make any changes? Or is it what we are looking at right now?

Assemblywoman McClain:
It is what we are looking at right now.

Vice Chair Gerhardt:
I am sure there will be a large amendment.

Assemblywoman McClain:
It is in the Committee on Ways and Means.

Vice Chair Gerhardt:
Seeing no questions, we will close the meeting on *S.B. 83*, and move to *Senate Bill 112 (1st Reprint)*.

Senate Bill 112 (1st Reprint): **Enacts provisions governing the sale of products containing materials that are used in the manufacture of methamphetamine and other controlled substances. (BDR 40-27)**

Senator Dina Titus, Clark County Senatorial District No. 7:
[Read (*Exhibit C*).]

Vice Chair Gerhardt:
Ms. Lutter compared the Attorney General's bill and your bill. You are right; it is very similar. Section 7 of the Attorney General's bill includes provisions on blister packs. From what I am gathering, we want to move ahead with your bill. What is your position on blister packs?

Senator Titus:
We want to add that provision to our bill. I believe that is in the federal statute and the Retail Association of Nevada is proposing an amendment.

Vice Chair Gerhardt:
There was another difference with the penalty.

Senator Titus:
Originally, there were criminal penalties for both the sellers and the buyers. We decided it is better that sellers be penalized with a civil penalty.

Vice Chair Gerhardt:
Does the Attorney General agree with this version?

Senator Titus:
Yes.

Liz MacMenamin, Director of Government Affairs, Retail Association of Nevada:
Senator Titus did an excellent job of bringing forth federal legislation that provides another tool for law enforcement. We have amendments to the bill.

[Read (*Exhibit D*).]

Vice Chair Gerhardt:
You want to change subsection 7 instead of 4 of Section 8?

Liz MacMenamin:
Actually, it is both subsections. The amendments state subsection 4 and 7. The Attorney General asked us to bring forward that amendment.

Assemblyman Hardy:
Is it two crimes and two trials at both the federal and state level? Who has jurisdiction?

Senator Titus:
The bill will allow the State to prosecute the crime first rather than the federal government. The State would have jurisdiction.

Assemblyman Hardy:
Would it be two crimes and two trials?

Senator Titus:
It would be one crime and one trial at the state level. As I understand it, state and federal government will collaborate. The case will not be tried in both courts.

Conrad Hafen, Senior Deputy Attorney General, Office of the Attorney General:
The primary reason for the state law is so the rural district attorneys can prosecute such crimes in their jurisdictions. Even though the federal law is in effect, federal officials may not have the resources to investigate related cases in rural jurisdictions and prosecute under the Combat Methamphetamine Epidemic Act of 2005. For the most part, federal officials will focus on large jurisdictions such as Clark County and Washoe County. The state law will give rural prosecutors the ability to enforce federal and state law. It is my understanding that officials at the federal and state level collaborate and determine what jurisdiction would have better resources to deal with the case. There is a statute that would preclude a state prosecutor from prosecuting a crime if the federal prosecutor has already obtained a conviction on the same type of crime. Does that happen? Yes, it does. However, we have a good

working relationship with the United States Department of Justice Office of the Attorney General. It is our hope that rural prosecutors will be able to prosecute under the state law without interference from the U.S. Office of the Attorney General.

Assemblyman Hardy:
If someone is arrested at the federal or state level, how does that person get prosecuted in the federal system instead of the state system?

Conrad Hafen:
If someone violated the law in Clark County and the U.S. Office of the Attorney General filed the prosecution first, it is unlikely that the Clark County District Attorney's Office will file charges. However, if the Clark County District Attorney's Office or the Office of the Attorney General filed charges against an individual in Clark County for violating state law, it is unlikely that the U.S. Office of the Attorney General will file criminal charges. We have to coordinate with the U.S. Office of the Attorney General and the Drug Enforcement Administration (DEA). Again, the point of the state law is to give rural prosecutors the opportunity to enforce federal law.

Assemblyman Hardy:
Could we include a provision that does not burden state prisons with convicts of rural or federal cases?

Conrad Hafen:
Rural prosecutors do not have jurisdiction to prosecute under the Combat Methamphetamine Epidemic Act. We could not file state charges under the Act and that is why we need a state law.

Assemblyman Hardy:
I am talking about a population cap. The rural convicts will be sent to State prisons while urban convicts are sent to federal prisons. It will decrease the financial burden on the state prison system.

Conrad Hafen:
I appreciate that concern, but if the DEA or the U.S. Office of the Attorney General chooses not to investigate a certain case, the case must be prosecuted by state officials. The state law is required for state officials to prosecute the case.

Chair Leslie:
Rather than go through more testimony, we should accept a motion.

Vice Chair Gerhardt:
Does anyone oppose the bill? [There was no response.]

ASSEMBLYWOMAN LESLIE MOVED TO AMEND AND DO PASS *SENATE BILL 112 (1ST REPRINT)*.

ASSEMBLYWOMAN PARNELL SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Appendix M

Vice Chair Gerhardt:
We will close the meeting on *Senate Bill 112 (1st Reprint)* and move to *Senate Bill 169 (1st Reprint).*

Senate Bill 169 (1st Reprint): **Adopts the Revised Uniform Anatomical Gift Act. (BDR 40-968)**

Senator Terry Care, Clark County Senatorial District No. 7:
Senate Bill 169 (1st Reprint) deals with the Uniform Anatomical Gift Act. The National Conference of Commissioners on Uniform State laws is an organization with about 250 members who actively participate in the appointments made by the states. Members include lawyers, judges, law school professionals, practitioners, and legislators.

The commission adopted a new act in 1987. There have been many changes and advances in technology and research so that a number of states created their own amendments to the original act. As a result, the law is no longer uniform. The intent is to update the original act and its amendments, and there is a nationwide effort to bring uniformity to this area. This legislation will create uniform rules for donor research.

Ethical issues, attitudes, and concerns have changed, and they are addressed in the bill. Numerous people developed the amendments that led to the first reprint of the bill. We heard testimony from doctors, coroners, and representatives from the donor community as well as the Department of Motor Vehicles (DMV). I will turn

it over to Michelle Clayton; she can explain the act in greater detail.

Michelle Clayton, Legislative Counsel, National Conference of Commissioners on Uniform State Laws:

[Submitted (*Exhibit E*), (*Exhibit F*), (*Exhibit G*), (*Exhibit H*), (*Exhibit I*), (*Exhibit J*).]

This act is popular among legislators this year. There are 25 introductions, 9 enactments, and 10 pending legislations. It is a major national push to improve the organ donation law because it has become very nonuniform. Organ donations occur across state lines, so it is very important that the law be uniform.

The amendments deal with medical examiner and coroner protocols with the Organ Procurement Organization. Even though many states will not be enacting the uniform provisions, state medical examiners and procurement organizations will collaborate to develop appropriate protocols. I am pleased because everyone agreed to this. The other amendments deal with research and education. We want to make sure that the act does not inadvertently impact the research and education aspects of organ donation.

The act provides appropriate language in harmonizing federal law with state law and strengthens the individual's right to donate or not to donate. It helps the procurement organizations by providing clearer rules and standards for donor registries. The online

donor registries are important to increase organ donations. I hope the Committee will support this bill.

Vice Chair Gerhardt:
Can you briefly summarize the bill?

Michelle Clayton:
Section 2 has new definitions. "Disinterested witness" is a person who verifies that an individual wants to donate. Two witnesses must be present, and one of them must be "disinterested." This is a way to protect a prospective donor. In the past, people would sign up to be donors, but after their deaths, their families did not want them to donate. As a result, organs could not be donated because of the wishes of the donor's family. This act will strengthen the first person consent and the disinterested witness ensures the donor's wishes will not be overturned.

Chair Leslie:
Would the disinterested witness be the person who witnesses the donor submitting his or her driver's license?

Michelle Clayton:
I am talking about an oral donation. Someone makes an oral statement that he wants to be donor, and a disinterested witness must be present.

Chair Leslie:
Is the driver's license process not worth doing?

Michelle Clayton:
It is absolutely worth doing. The DMV provides information to the donor registry.

Chair Leslie:
It seems there is an override mechanism.

Michelle Clayton:
No. The new bill will strengthen the individual's right to donate. In the past, hospitals and procurement organizations were reluctant to honor those wishes.

Chair Leslie:
Is there a provision in the bill that addresses the driver's license issue?

Michelle Clayton:
I am not familiar with how Nevada's system works.

Chair Leslie:
I want to know if that is happening.

Michelle Clayton:
It has happened in some states, and that is why we want to strengthen . . . .

Chair Leslie:
We will hold that question; we want to get through the bill.

Appendix M

Michelle Clayton:
The definition of "organ procurement organization" is important as it provides the organizations with more guidance. Section 9 provides a list of people that can donate. There are new definitions on electronic language that recognizes emails, the donor registry, and so on. There are about 20 new definitions; they are useful in clarifying the law.

Section 22 states who may make an anatomical gift before the donor's death. Section 23 describes the various ways a donor can make a gift. Section 24 describes how to amend or revoke a gift before the donor's death. One should be very clear about his wishes on organ donation, and this act ensures those wishes will be honored. Section 29 deals with who can receive an anatomical gift; it clarifies which organs go to the organ banks. Section 30 deals with the search of an individual's driver's license, and Section 31 deals with the delivery of the gift document. Section 32 is about the rights and duties of procurement organizations and provides more clarification of what the DMV does with the donor registry.

A new provision in Section 34 states, "A person shall not, in order to obtain a financial gain, intentionally falsify, forge, conceal, deface, or obliterate a document of a gift, an amendment for revocation of a document of a gift, or a refusal." Section 35 provides immunities for those acting in good faith, and protections for the organ procurement organizations. Section 37 lists the new donor registry requirements, which include the basic

standards for donor registries. Section 38 deals with advance health care directives, and we provided an amendment to this section. In a case in which a prospective donor has a living will and signed to be an organ donor, the agent and the doctor will decide what the patient would have wanted. Section 39 and Section 40 provides provisions on medical examiners and coroners.

Assemblywoman Parnell:
A friend's son died at nine years old, and the family was asked if they would like do an organ donation. The family agreed; it was a positive side to a tragic incident. They found out that the organs were not taken, and they were devastated. I am wondering if the new language would have prevented this situation.

Michelle Clayton:
It is one of our goals that organ donation occurs in as many cases as possible, but it depends on the resources of each state. The National Association of Medical Examiners is working with the Association of Organ Procurement Organizations to make sure protocols are developed so that situation does not happen.

Assemblywoman Parnell:
I passed the issue to constituent services; there was an investigation to figure out what went wrong. Once I find out more information, perhaps there will be time to amend the bill.

Appendix M

Senator Care:
I circulated the act to the Nevada Donor Network and the Office of the Clark County Coroner. Both had concerns about Sections 30 and 40; other legislators were also concerned. It was decided that the donor network and coroner should develop protocols.

Michelle Clayton:
There is nothing in the statute that deals with the protocols between medical examiners and the donor network. I hope the act would be an improvement.

Assemblywoman Parnell:
I want to make sure that the language does refer to the body. For instance, a body tested positive for drugs. Certain organs should not be used, but there are other parts of the body that could be donated.

Michelle Clayton:
Approximately 50 people can be helped by the organ donation of one person.

Assemblywoman Weber:
Are there prohibitions in the bill? I have a background in blood donation. What happens when an organ donor ends up in prison where infectious disease is prevalent? Does the bill address infectious disease and prohibitions?

Michelle Clayton:
No, I do not think it does. Blood bank laws are different from anatomical gift laws.

Assemblywoman Weber:
Is it exempt?

Michelle Clayton:
I do not think that is within the scope.

Ken Richardson, Executive Director, Nevada Donor Network:
The Nevada Donor Network is a federally designated organ procurement organization for southern Nevada. To answer Ms. Weber's question, we follow the guidelines provided by the Center for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA). We are subject to their regulations for infectious disease; it is regulatory, not statutory. The guidelines do not need to be included in the bill.

Regarding the question on first person consent, former Assemblywoman Dawn Gibbons and former Attorney General Frankie Sue del Papa collaborated in 2001 to make changes to the act, which created Nevada's donor registry. It works very well. Because of the DMV and a third party contractor, we have been a first person consent state since 2001. If an individual indicates that he wants to be a donor, his consent is primary so no one can overrule that. The proposed legislation will not change that; it will simply strengthen the existing statute.

Appendix M

Chair Leslie:
That was my understanding. When Ms. Clayton said that was not happening, it raised some concerns. Does that comment not apply to Nevada?

Ken Richardson:
Correct, it does not apply to Nevada.

Chair Leslie:
So it has not happened in Nevada?

Ken Richardson:
In practice, we are notified when someone passes away. We access the donor registry to determine if the individual is an organ donor. There are 700,000 Nevadans signed to the registry.

Michelle Clayton:
I want to apologize if I caused any confusion. This has been a problem across the country since 1968.

Chair Leslie:
That is fine just as long as it is not a problem for us.

Ken Richardson:
Since 2001, we have not had that problem.

Vice Chair Gerhardt:
Section 22 states who can be a donor. For example, a 16 year old wants to be donor and indicates that on his driver's license. What happens when the parents do not want that for their child?

Appendix M

Ken Richardson:
There is potential conflict. The age of 16 is not the age of consent; the individual must be 18 years old. Even though the 16 year old wishes to be an organ donor, we must seek the consent of the legal guardians.

Michelle Clayton:
The legislation allows minors to indicate their wishes.

Vice Chair Gerhardt:
Under those circumstances, it will assist the parents.

Michelle Clayton:
Yes.

Assemblywoman McClain:
What if someone is not on the registry? Will the family be allowed to donate the individual without his consent?

Michelle Clayton:
If someone is not on the registry, then he has not made the decision.

Assemblywoman McClain:
If someone wishes to refuse organ donation, will that be indicated on the driver's license?

Michelle Clayton:
No.

Appendix M

Assemblywoman McClain:
If there is no indication of refusal on the driver's license, we do not truly know if the individual refused organ donation. Perhaps the individual might want to donate.

Ken Richardson:
We advise people to talk to their families about their wishes. Some people want to be donors, but do not want to indicate that on their drivers' licenses because the moment they do, they will die. There is a certain amount of superstition in that context. We encourage folks to talk with their families. Unfortunately, donor registries include only people who want to be organ donors. It does not include people who do not want to donate or who are undecided.

Vice Chair Gerhardt:
Can one put his wishes in a living will? The family does not necessarily get the final word?

Ken Richardson:
That is correct.

Lawrence Matheis, Executive Director, Nevada State Medical Association:
We are presenting an amendment on behalf of the Organ Tissue Task Force, which is co-chaired by First Lady Dawn Gibbons and former Attorney General Frankie Sue del Papa.

[Read (*Exhibit K*).]

Appendix M

Chair Leslie:
Are there provisions for donations of bodies for research? My dad had cancer, and he donated his body for research. After his body was used for research, they were supposed to return his remains to my mother, but that was not done. Eventually, we found his remains. Does the bill address that situation?

Lawrence Matheis:
I believe that was addressed last session, but I will have to get back to you on that.

Chair Leslie:
Does the act address that situation?

Michelle Clayton:
No, we do not deal with whole body donations, but we are contemplating a uniform law in this area because it is highly unregulated.

Lawrence Matheis:
I believe protocols were developed last session.

Vice Chair Gerhardt:
Does the act address what happens to out-of-state visitors who are organ donors?

Michelle Clayton:
The document of gift is valid if it is valid in Nevada and the home state.

Appendix M

Lawrence Matheis:
[Continued to read (*Exhibit K*).]

Vice Chair Gerhardt:
We will take your amendments to work session. Senator Care, are you fine with that amendment?

Senator Care:
Yes, there is no objection.

Lawrence Matheis:
I will rewrite the amendments and place them in the appropriate order.

Ken Richardson:
I want to clarify what Senator Care said. We worked with the Office of the Clark County Coroner to address the conflict between organ donation and preserving forensic evidence. We put together workable protocols that will resolve those issues while preserving the intent of the act.

Terence Ma, Director of Technology, Touro University Nevada:
I went to the meeting of American Association of Anatomists in Washington D.C. and everyone in the profession supports this bill. We strongly urge the Committee to pass the bill.

Appendix M

Clay Thomas, Deputy Director, Nevada Department of Motor Vehicles:
I would like to thank Senator Care for listening to us and Mr. Matheis for developing the amendments.

Vice Chair Gerhardt:
Seeing no other questions, we will close the hearing on *Senate Bill 169 (First Reprint)* and open the hearing on *Senate Bill 529 (First Reprint)*.

Senate Bill 529 (1st Reprint): **Revises certain provisions relating to Medicaid. (BDR 38-601)**

Charles Duarte, Administrator, Division of Health Care Finance and Policy, Department of Health and Human Services:
[Submitted (*Exhibit L*) and (*Exhibit M*).]

[Read (*Exhibit L*).]

Vice Chair Gerhardt:
Mr. Duarte, I am going to interrupt you. I need some clarification. What happens when an individual who has Medicaid gets a settlement from an accident? Will the State take a part of that settlement?

Charles Duarte:
No, not exactly.

Appendix M

Sabrina Raetz, Deputy Attorney General, Office of the Attorney General:
In that scenario, the individual's medical bills are paid by Medicaid and the person sues the liable third party through an attorney. They are able to acquire a recovery through a judgment, award, or settlement. Prior to *Arkansas v. Ahlborn* [*Arkansas Department of Health and Human Services et al. v. Heidi Ahlborn* 547 U.S. 268 (2006)], attorneys would deduct fees and the Medicaid program would take the value of the lien or the remaining settlement. Ms. Ahlborn argued that the states did not have the right to do that. Under the federal law, the Medicaid programs could recover only the judgment, settlement, or award that was allotted to medical damages. The U.S. Supreme Court upheld Ms. Ahlborn's case.

Vice Chair Gerhardt:
Will this bill change the existing statute so that it complies with the U.S. Supreme Court ruling?

Sabrina Raetz:
Attorneys receive lump sum payments; there is no allocation for medical damages. States tried to determine how to allocate a portion of a judgment, settlement, or award for medical damages because there was no way of doing that. What portion of someone's award is allocated to medical damages? We are trying to develop cost effective ways to determine what portion of the awards are allotted to medical damages. In some instances, there are cases that go to trial, and a jury or a judge will allocate the award. This does not include

these cases. Generally, a settlement is reached, but the award is not allocated. This bill attempts to provide allocations for medical damages.

Vice Chair Gerhardt:
How often does an allocation not take place?

Sabrina Raetz:
It happens in most cases. Since the Ahlborn case, I had only one case where that happened.

Vice Chair Gerhardt:
The legislation will allow the State to collect 100 percent of the lien?

Sabrina Raetz:
Absolutely not.

Vice Chair Gerhardt:
How are we getting those percentages?

Sabrina Raetz:
We will not collect. Medicaid tried to develop reasonable means to allocate awards; they wanted a clear statutory payment system. Section 8 states there is a three-way split. In cases where there is no allocation of the settlement, the award will be split equally between the attorneys, the recipient, and Medicaid.

Charles Duarte:
We have data on four state laws. In all those examples, there are different proposed percentages. Nevada has the lowest proposed percentage; I believe it is one-third.

Sabrina Raetz:
That is correct. After the Ahlborn decision, plaintiff attorneys decided not to allocate a portion of the award to medical damages. My colleague and I have been on cases where attorneys allocated only $7,000 to medical damages of a $500,000 award.

Vice Chair Gerhardt:
Section 18 states, "The full value of the Department's lien created pursuant to section 2 of this act." Is it whichever is less?

Sabrina Raetz:
That is right.

Assemblywoman McClain:
If you collect one-third of the award, half of that will go to the federal government?

Charles Duarte:
Yes, we have to repay the federal government with a portion of the recovery. The bill complies with the decision of the Ahlborn case. We are proposing an efficient, reasonable, and fair way to allocate a portion of any settlement to Medicaid costs. We discussed this with the American Trial Lawyers Association, and they are opposed. If we are required to go to trial on all cases, we will need to impose a fiscal note. The Office of the Attorney General's caseload will increase, additional staff will be needed, and the net amount of the recoveries will decrease because of the increase of costs. We are very concerned about this during lean fiscal times. We

are missing an opportunity to retain a level of recovery that we have through our current subrogation program.

[Continued to read (*Exhibit L*).]

Assemblywoman McClain:
How does someone qualify for Medicaid if he has health insurance?

Charles Duarte:
Medicaid is an entitlement program that is based on disability, age, income, and assets. It is not based on whether or not the individual has secondary health insurance. Many people have employer sponsored insurance, which is always a primary insurance. Medicaid pays after the primary insurance pays. Another secondary insurance is Medicare. Currently, about 22 percent of our recipients have secondary insurance.

Assemblywoman McClain:
I knew about Medicare, but I did not think a Medicaid recipient would have health insurance. Medicaid is based on income, right?

Charles Duarte:
That is correct. Many recipients are working people; they might have employer sponsored coverage or perhaps the employer pays the full cost of coverage for his employee premiums.

Assemblywoman McClain:
Their income level is that low?

Charles Duarte:
It is very likely. There are a lot of low-wage earners who have health insurance. We try to identify them and their health insurance companies. It is a benefit to providers because commercial health insurance pays better than Medicaid.

Vice Chair Gerhardt:
It probably is not as comprehensive.

Renny Ashleman, representing Nevada Health Care Association:
Mr. Duarte consulted with us on the provider tax. We support that portion of his proposed legislation. We are proposing several amendments.

[Read (*Exhibit N*).]

Vice Chair Gerhardt:
Did any attorney groups view the amendments?

Renny Ashleman:
Some representatives from elder care attorney groups were involved indirectly. We did a survey of the problems in this area; this language came from the survey. I cannot say that all of them endorsed the language, but from my familiarity with the survey, I do not think they would have a problem with this language.

Appendix M

Matthew L. Sharp, representing Nevada Trial Lawyers Association:

I am here on behalf of the Nevada Trial Lawyers Association. We oppose the lien provisions of the bill. The decisions of the Ahlborn case were unanimous, and this case provides a real life example of what we are talking about. When an individual comes to my office seeking recovery from a personal injury claim, our law provides a remedy in the form of money. The money can pay for medical bills, lost earnings, pain, distress, and so on. In the context of a personal injury claim, we do not have a problem paying Medicaid a fair portion of the settlement.

We do not live in a perfect society. If a drunk driver runs over a child and leaves the child brain damaged for life, the responsible party usually does not have enough insurance to compensate the child. The amount Medicaid recovers should be fair and proportionate to the settlement. This is what the U.S. Supreme Court decided.

According to the U.S. Supreme Court opinion, Heidi Ahlborn, a young college student, suffered severe and permanent injuries from a car accident. She was brain damaged and unable to complete her college education. Her case settled for $550,000. The total cost of her damages, stipulated by Medicaid, was $3 million. The U.S. Supreme Court decided that if a case like that is settled for $550,000, Medicaid reimbursements should be proportionate to the total recovery. In this case, it

was one-sixth of the total recovery. It is an equitable remedy.

People may wonder why the case was settled at $550,000 instead of $3 million. There are a number of reasons. In Nevada, an individual recovers an amount proportionate to his own negligence. For example, if someone is at fault 10 percent, he would recover 90 percent of the damages. You do not want to discourage the most severely injured individuals from pursuing a lawsuit or force the lawsuit into trial because Medicaid wants to be reimbursed. We want fair settlements. It is onerous for attorneys to represent Medicaid instead of their clients. A client risks losing a case and paying for fees, but Medicaid is at no risk in these situations. Medicaid does not put any time into the case, yet it wants one-third of the recovery irrespective of the compensation.

Heidi Ahlborn received $550,000 from the case, and she would allot one-third for attorney fees and one-third for Medicaid, leaving her with less than 30 percent of the total recovery for a lifetime of lost earnings and brain damage. That is not fair. How would the Committee establish an interest in Medicaid? According to the U.S. Supreme Court, the federal law limits Medicaid rights in proportion to the amount that is recovered. We suggest two things: do not change the law because the existing statute already complies with Medicaid, or if the law will be changed, develop a simple mechanism that allows Medicaid the ability to seek a good faith termination from the court. There are people that believe this will result in a fiscal note. At a certain point,

Medicaid has a responsibility to step up and protect our interests. They should not be able to ride the coattails of the attorney and the client without financial risk.

For example, an individual is injured by a drunk driver, but the driver has only $50,000 of insurance. Under this bill, many lawyers will decide it is not worth the client's time or risk. The attorneys and Medicaid will get their portion of the settlement, but what about the client? There has to be a balance so people will have the ability to pursue their rights, and Medicaid gets a fair portion. Court intervention is required in the event the attorneys and Medicaid cannot agree to an amount.

Assemblyman Hardy:
I did not hear a response to the scenario where the client does not receive money for medical damages.

Matthew L. Sharp:
I am not going to say that certain abuses will not occur. There are some people who do not act ethically. If an attorney refuses to allot a portion for medical damages, the law says one is entitled to pay the fees and costs of the opposing party. There were cases like Ahlborn where attorneys legitimately believed their clients were not getting full compensation.

Assemblywoman Pierce:
How did this work before the Ahlborn case?

Appendix M

Matthew L. Sharp:
I do not think it worked very well. Medicaid was entitled to a first dollar recovery. Medicaid would get first dollar recovery in a $500,000 settlement with $3 million in total damages and $200,000 in medical bills. We disagreed with that interpretation; we attempted to negotiate with Medicaid.

Vice Chair Gerhardt:
Did you talk with other interested parties about your concerns?

Matthew L. Sharp:
I had discussions with Medicaid representatives. They feel strongly about their position, and we feel strongly about our position. We did not reach a resolution.

Vice Chair Gerhardt:
Mr. Duarte, can you meet again so both sides can reach middle ground? We need legislation that addresses everyone's concerns.

Charles Duarte:
Yes. Prior to this session, we held a public workshop on this bill, and no public comment came forward in opposition to the bill. We had discussions with Mr. Sharp and we had scheduled to meet again yesterday. He did not call; I assumed he still opposed the bill and had nothing more to provide. We are always open to compromise, but we do believe it will impede our ability to recover funds.

Appendix M

Vice Chair Gerhardt:
I think we need to look at the issue more. Ms. Pierce, would you consider chairing a subcommittee or working group?

Assemblywoman Pierce:
Yes, a working group.

Vice Chair Gerhardt:
Who would be on this group? I will volunteer my services. How about Ms. Weber? Let us take another look at this issue. Obviously, this is not a workable plan. Are there other questions? [There was no response.] This meeting is adjourned [3:40 p.m.].

RESPECTFULLY SUBMITTED:

_____

Katrina Zach
Committee Secretary

APPROVED BY:

_____

Assemblywoman Susan I. Gerhardt, Vice Chair

DATE: _____